2007 Community Mental Health Services Block Grant Application and State Plan

Annual Date of Submission – September 1

Adult & Children and Youth Services
July 1, 2006 – June 30, 2007

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Since January 1, 1994, Tennessee's public health system has operated under a Medicaid waiver managed care program. TennCare provides medical services through Managed Care Organizations, and the TennCare Partners Program provides behavioral health care services through Behavioral Health Care Organizations. TennCare provided services to persons with Medicaid and to other non-Medicaid waiver eligible individuals meeting specific criteria as uninsured or uninsurable. Since its inception, from 1.2 to 1.6 million individuals annually were eligible to receive services through TennCare.

Due to increasing budget constraints, a restructuring package was developed and approved in early 2005 that significantly decreased the TennCare waiver population. Over the next six months, some 191,000 adults were scheduled to lose eligibility for TennCare. Of that number, approximately 21,000 were identified as active mental health priority population adults.

The Department of Mental Health and Developmental Disabilities, in partnership with community providers and advocates across the state, developed a core service package for that identified group of adults with SMI facing loss of benefits, called the Mental Health Safety Net program. This service package is designed to at least meet basic medication and treatment needs of these individuals, and eligibility has since been expanded to any of the disenrolled population being assessed as meeting the criteria for the mental health priority population.

The result of very hard work in very little time by the Department and its provider partners, the mental health safety net program has been largely successful. Nearly 60% of disenrolled adults in the priority population have registered with a community mental health agency for services, and inpatient utilization has not significantly increased as feared. Methods of monitoring the disenrolled population continue in order to outreach for service connection and assure that emergency rooms and jails are not becoming service alternatives. It is anticipated that a new state health care initiative, Cover Tennessee, will assist with the health care needs of some uninsured and uninsurable adults formerly enrolled in TennCare.

Transformation activities in keeping with the President's New Freedom Commission Goals continue in the areas of anti-stigma efforts, suicide awareness and intervention, consumer-run services, systems of care, school-based early intervention, consumer and family education and training, and workforce development.

Mental Health Block Grant funding continues to provide significant support for recovery-oriented, consumer-run services for adults and identification and early intervention services for children and youth. Additionally, these funds have allowed for the implementation of needed initiatives in mental health and criminal justice, older adult service integration, supported housing, consumer and family education and support, suicide prevention, respite services and system of care expansion.

An abbreviations glossary is included with this Block Grant Application and Plan as Appendix 8.

PART B. ADMINISTRATIVE REQUIREMENTS

Section I: Federal Funding Agreements, Certifications and Assurances

Original signature copies submitted by overnight mail.

4. Public Comments on State Plan

Public comment is solicited by dissemination of the draft plan to members of the Statewide Mental Health Planning and Policy Council, the seven Regional Mental Health Planning and Policy Council Chairs, the Departmental Mental Health and Developmental Disabilities Council, Department of Mental Health and Developmental Disabilities (DMHDD) staff and anyone else requesting a copy. This effort directly reaches over 200 individuals but, through copying and sharing with various Council member constituency groups, reaches a much broader audience.

For the working draft of the 2007 Block Grant Plan, web-based "read and comment" access instructions were forwarded to members of all planning councils and consumer and family advocacy groups in July 2006, instructions were posted on the Department's web site for general public access, review and comment on July 19, 2006, and an electronic copy was distributed to State Mental Health Planning and Policy Council members on August 2, 2006.

Any questions and/or comments not entered directly on the site may be directed to the Mental Health Planner responsible for preparing the grant.

Mental Health Planning Council comments or recommendations are generally forwarded to the Council Chair for inclusion into the Council response letter that accompanies the Block Grant Plan submission. A copy of the most current Community Mental Health Block Grant Plan and Implementation Report is maintained on the Department's web site.

Section II: Set-Aside for Children's Mental Health Services

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by: **State FY X**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2005	Actual FY 2006
$4,802,031	$18,605,982	$19,098,430

Section III: Maintenance of Effort (MOE)

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Information Reported by: State FY X

State Expenditures for Mental Health Services

Actual FY 2004	Actual FY 2005	Actual FY 2006
$257,074,047	$300,186,112	$204,888,023

IV. State Mental Health Planning Council (SMHPC) Requirements

1. Council Membership List – Appendix 1
2. Council Membership Composition – see table below.

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	**41**	
Consumers/Survivors/Ex-patients (C/S/X)	9	
Family Members of Children with SED	2	
Family Members of Adults with SMI	7	
Vacancies (C/S/X & family members)	0	
Others (not state employees or providers)	5	
TOTAL C/S/X, Family Members, and Others	**23**	**56%**
State Employees	10	
Providers	8	
Vacancies	0	
TOTAL State Employees & Providers	**18**	**44%**

3. Planning Council Charge, Role and Activities

DMHDD has a three-tiered system of advisory councils. A council flow chart and regional map are included with this application as Appendices 2 and 3. Simply put, delegates from councils in each of seven regions have representation on state planning and policy councils for mental health and developmental disabilities, and current or previous state-level council members have representation on a Department of Mental Health and Developmental Disabilities Planning and Policy Council (MHDDPC).

DMHDD is actively recruiting cultural minorities, transitional age (18-21) youth and caregivers of young children with SED for all Council memberships. SMHPC members serve three-year terms, and bylaws specify a maximum membership of forty-five. For FY07, it was agreed that at-large vacant membership positions would not be filled so that, if recruiting efforts are successful, new members could be appointed throughout the year. It is noted that two of the members designated as family members of adults with SMI are parents of transitional age youth.

Pursuant to Public Law 102-321 and T.C.A. Sections 33-2-202 and 33-2-203, the principal purpose of the SMHPC is to provide citizen participation to assist and advise the DMHDD in planning, policy development and oversight of the state's comprehensive mental health service system for persons of all ages with mental health needs, including adults with SMI and children and youth with SED. More specifically:

2.1 The Council shall review the annual Mental Health Block Grant plan and make recommendations.

2.2 The Council shall serve as an advocate for adults with SMI and for children with SED and other individuals with mental illnesses or emotional problems by providing public mental health education and awareness activities and promoting non-discriminatory policies and practices.

2.3 The Council shall monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state including review of monitoring and evaluation reports pertaining to the implementation of the state's mental health program.

2.4 The Council shall advise the DMHDD Planning and Policy Council on the Three Year Plan including the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families, and such other matters as the Commissioner of DMHDD or the DMHDD Planning and Policy Council may request.

2.5 The Council shall provide information and advice to the Department on policy, formulation of budget requests, development and evaluation of services and supports, and on other matters as requested by the Commissioner of DMHDD or the DMHDD Planning and Policy Council.

The complete Mental Health Planning and Policy Council Bylaws are attached as Appendix 4.

The SMHPC, through its statewide representative membership and committees, plans and advises on efforts in the areas of consumer and family advocacy, cultural competence, criminal justice, service delivery, managed care, discrimination, housing, employment, public policy, and planning.

Data and performance reports are reviewed on a variety of service initiatives as requested. Information on regional funding allocations, service outcomes and program compliance are made available for review.

The Council further reviews and advises annually on both the Block Grant Plan and the Department's Three Year Plan and has member participation on the MHDDPC, which replaced the Board of Trustees under mental health law revision in 2001.

During state FY06, Council activities were focused on monitoring awareness of and access to the MHSN program for TennCare disenrollees with SMI. The Council played a significant role in shaping the program; advocating for flexibility in the service package based on consumer need, inclusion of critical medications in the formulary, and expansion of the eligible population.

The SMHPC has historically advocated for reduced stigma, suicide prevention, increased housing and employment options, increased consumer and family participation in treatment and service planning, integrated treatment, better interagency collaboration, and “paying for services that work”; that is, evidenced based and best practices. Indeed, it is the input of consumer and family stakeholders and advocates that inspired, and will continue to guide, the transformation of mental health care in Tennessee and across America.

In addition to routine activities of reviewing Block Grant and state funding allocations and services, available data reports, statewide needs assessment information and proposed annual Three Year Plan revisions, the Council made recommendations on the Request for Proposal for a new managed care contract for the Middle Tennessee area. Two key Council concerns were: 1) that if a mental health “carve-in” plan is chosen, that physical and mental health issues be holistically and practically integrated, and 2) that any managed care organization embrace a recovery/resiliency orientation in treatment policy.

DMHDD recently published *Managed Care Standards for the Delivery of Behavioral Health Services*, which states: “All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance abuse issues.” Definitions of recovery and resiliency are based on the 10 Fundamental Components of Recovery and on the System of Care Values and Principles endorsed by SAMHSA and CMHS.

4. State Mental Health Planning Council Comments and Recommendations

Original signature copy of Council letter submitted by overnight mail.

PART C. STATE PLAN

SECTION I. Description of the State Service System

Overview of the Mental Health System

The state system of behavioral health care for adults and children and youth consists of four major service delivery entities:

1. TennCare and the TennCare Partners Program (TCPP) provide medically necessary medical and behavioral health care services.

   - TennCare provides medical and behavioral health services through various Managed Care Organizations (MCOs) and Behavioral Health Care Organizations (BHOs). As of May 31, 2006, nearly 1.2 million persons meeting select categories of Medicaid eligibility were enrolled in the TennCare Program; generally 50% age 18 and over and 50% under age 18. Approximately 10% of adult TennCare enrollees and 4% of children and youth TennCare enrollees met the criteria for adults with SMI or children and youth with SED. TennCare is a responsibility of the Department of Health (DOH), Bureau of TennCare, and is administratively responsible to the Department of Finance and Administration (DFA).

2. The Department of Mental Health and Developmental Disabilities (DMHDD) contracts for services to adults and children and youth in education, prevention, early intervention, support, recovery, and model program development and for mental health safety net (MHSN) services for TennCare disenrolled adults assessed as being in the mental health priority population.

   - DMHDD maintains state and federally funded grant contracts with forty-three private, non-profit community mental health agencies (CMHAs) and other organizations that provide a variety of services that are either not available or not fully supported through the TCPP.

   - DMHDD contracts with twenty CMHAs to provide MHSN services to adults disenrolled from the TennCare waiver population.

   - DMHDD administers five state operated psychiatric hospitals, referred to as Regional Mental Health Institutes (RMHIs).

3. The Department of Health (DOH), Bureau of Alcohol and Drug Abuse Services (BADAS), provides contracted services under TennCare and education, prevention, and substance abuse treatment services to non-TennCare adults and children through the Substance Abuse Services Block Grant.

4. The Department of Children's Services (DCS) is responsible for provision and oversight of services to children in or at risk of state custody. Services provided by DCS include child protective services, foster care, adoption, programs for delinquent youth, probation/aftercare and treatment and rehabilitation programs for identified youth.

FY06 Summary of Areas Needing Attention and Accomplishments

ADULT service needs were identified in the FY06 needs assessment process. These included: 1) alternatives to hospitalization, including models effective for rural areas; 2) increased anti-stigma efforts; 3) mental health education for primary care providers; 4) development of a peer specialist program; 5) expansion of services for consumers interfacing with the criminal justice system; 6) continued efforts in consumer and family support and education services, and 7) the promotion of recovery-oriented services, including transportation, employment and housing.

With the recent reform in the TennCare system, further anticipated needs include the development of resource options for those without health care insurance, monitoring of disenrollees, and evaluating the effectiveness of MHSN services.

Alternatives to hospitalization: The Chattanooga Crisis Stabilization Unit (CSU) continues to provide successful intervention for persons in psychiatric crisis, reporting a 97% rate in FY05 for diversion from inpatient services. Several other regions of the state have developed plans for establishing CSUs, but the lack of financial resources for staffing is a barrier to completion.

Anti-stigma efforts: New efforts include: "Arts for Awareness" - an exhibit of consumer art at the Legislative Plaza and in many agencies across the state; the DMHDD Commissioner's "Overcoming Stigma Campaign", a multi-year project with a 2006 focus on community business leaders; and the adaptation of three Commercial/Public Service Announcements with the assistance of the Alabama Mental Illness Planning and Advisory Council and a Housing Within Reach grant.

Mental health education for primary care providers:
The DMHDD Division of Clinical Leadership is leading a collaborative effort to educate primary care providers and human service professionals about mental health issues across the lifespan by providing informative materials that include screening tools and referral resources for use by primary care physicians and human service professionals.

Develop a Certified Peer Specialist Program: The forty-nine Tennessee Drop-in Centers were renamed Peer Support Centers, with statewide training for consumer staff in recovery-oriented philosophy and activities planning. A guidebook was developed in collaboration with the TN Mental Health Consumers' Association (TMHCA) to standardize peer support job performance, including education to better understand the recovery process. Wellness Recovery Action Plans (WRAP) is being implemented in the Peer Support Centers. A FY07 budget improvement request for Peer Support Recovery Specialist positions in each of the seven mental health planning regions was not funded; however, staff are moving forward with developing a certification process.

Adults involved with the criminal justice system: The criminal justice mental health liaison program has expanded to sixteen staff serving twenty-one counties, providing services to adults with behavioral health needs in jails, diversion activities, and education and training for law enforcement and court personnel. A FY07 budget improvement request for additional positions was not funded.

Continued efforts in consumer/family support and education services: DMHDD partners with the Tennessee Chapter of the National Alliance for the Mentally Ill (NAMI-TN) to educate family members about mental illness, its treatment and recovery, using the "With Hope in Mind" educational program and TMHCA to educate consumers about mental illness, its treatment and recovery, using the BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support) educational program.

Promotion of recovery-oriented services, including transportation, employment and housing: DMHDD is dedicated to promoting a recovery orientation throughout the behavioral health service system. The development of a division dedicated to recovery services through the SETH (Support, Employment/Education, Transportation and Homeless/Housing) initiative, the support of consumer and family education programs, widespread access to Peer Support Centers, and the number of consumer staff within the mental health system attest to that truth.

In addition, DMHDD and Magellan, the parent company of Tennessee's Behavioral Health Organizations, in partnership with the TN Association of Mental Health Organizations (TAMHO), TMHCA, TN Voices for Children (TVC), and NAMI-TN, met to plan for a statewide symposium on resiliency/recovery to be held in FY07. Goals of the proposed conference include: develop a shared consensus on the definition of recovery; align philosophy, policy, contracts and incentives to promote resiliency/recovery; and create a collective enthusiasm for recovery-oriented models across service sectors.

DMHDD staff have been active in the Department of Transportation's statewide planning efforts and will be involved in discussions around consumer transportation needs as a public transit system is developed in the city of Murfreesboro in Middle Tennessee next year.

The Creating Jobs Initiative kick-off occurred in cities across Tennessee in FY06 with a goal of increasing the number of persons with mental illness employed statewide by 2,010 persons by 2010.

The Creating Homes Initiative continues efforts to increase safe, appropriate and affordable housing options for behavioral health consumers across the state with more than 4,400 units developed or improved since 2002.

Monitoring and evaluation of MHSN services: A basic package of services was developed for adults with SMI losing TennCare eligibility during TennCare reform. Service eligibility was expanded to include any of the adult disenrolled population who receive an assessment of SMI.

As of August 14, 2006, 21,641 of 26,220 TennCare adults with any prior assessment of SMI had been officially disenrolled; 58% of them have registered for MHSN services. An additional 1,878 have been assessed as SMI since their disenrollment. Of the total 14,370 adults registered for MHSN services, 12,506 of them received 104,711 services through July 2006. More than $14.4 million was expended for services and medications. The top three services provided were psychiatric medication management, case management and individual therapy. Disenrollees with SMI are being tracked to determine the impact of loss of health care benefits and the adequacy of MHSN services.

CHILDREN AND YOUTH service needs were identified in the FY06 needs assessment process. These included 1) a continuum of school-based behavioral health care-preschool through college; 2) programs for transitional age youth (leaving state custody, moving to adult services, or needing to develop independent living skills); and 3) mental health liaison projects for children and youth interfacing with the juvenile justice system.

School-based behavioral health care: DMHDD supports a number of school initiatives for children and youth. These include: Child Care Consultation for pre-school teachers; BASIC, a school-based prevention/early intervention program for K-3; the Jason Foundation curriculum in middle and high schools geared to educating teachers, students and parents about the signs of suicide and to give them the tools and resources needed to identify at-risk youth; a middle school alcohol and drug/mental health prevention program and Mental Health 101, a school-based outreach to middle and high school students who have a parent with mental illness.

Department of Education funding provided to DMHDD supports two school-based Mental Health Liaison positions in Davidson County to provide face-to-face consultation with classroom teachers to assist them in structuring the classroom to enhance the learning environment for children with SED.

An FY07 improvement request to expand BASIC and school-based mental health liaison positions was not funded.

Programs for transitional age youth: Youth Villages, a non-profit organization, provides a transitional living program for children aging out of foster care and state custody. The program has served over 800 youth since 2001, with excellent two-year post services outcomes in living situation, education attainment and employment success as compared to the general population of youth leaving state custody.

DMHDD's current Three Year Plan contains a strategy to partner with DCS to assess the mental health service needs of transitional/high-risk youth. A survey is being completed by various state departments serving adolescents to determine definitions of, and current service initiatives for, youth of transitional age. Goals are to are to develop a common definition of this population and initiate MOUs to detail how departments can work together to provide needed services.

New Developments and Issues

Responding to an alarming increase in current and projected costs of the program, a TennCare restructuring package was implemented during FY06. Adults not meeting an open Medicaid eligibility category received a letter of disenrollment from TennCare.

With recognition of the potential adverse affects of the loss of health care coverage on a vulnerable population, nearly $104 million was appropriated to strengthen a health care safety net system. Approximately $53 million was dedicated to priority population adults who lost TennCare.

Disenrolled adults register with one of twenty CMHAs to receive a service package that includes the following: Assessment, Evaluation, Diagnostic, and Therapeutic Interventions; Psychiatric Medication Management and related Lab Processing; Case Management; Pharmacy Assistance and Coordination and access to reduced-cost or free generic medications.

Over half of eligible persons have registered for this service package, and outreach continues to those not yet registered. Despite initial fears, the mental health population has not appeared to suffer extreme negative consequences from TennCare reform. Persons needing substance abuse services and medical care may have been more acutely impacted.

TennCare reform resulted in some significant reductions in total dollars expended in the behavioral health service system. Compared to FY05, in FY06 there was an 11% decrease in total capitation payments to the BHOs and a 47% reduction in pharmacy costs. While there was a 30% increase in the amount of state and federal dollar allocations to community providers through DMHDD contracts, there was an overall decrease of 26% in total dollars directed for the provision of mental health services in Tennessee.

In addition, expended dollars above revenue received for the five RMHIs increased by 41% from FY05 to FY06.

It is estimated that over 600,000 Tennesseans have no health insurance coverage. In a proposal to help uninsured citizens, Governor Phil Bredesen proposed the "Cover Tennessee" Plan, signed into law in June 2006.

The initiative has targeted strategies to create health coverage options for persons who are uninsured:

CoverKids: A partnership between the state and federal government to extend comprehensive health coverage to every uninsured child in the state.

AccessTN: A premium assistance plan for seriously ill adults able to afford health coverage, but who have been deemed uninsurable by insurance companies.

CoverTN: A plan to provide guaranteed, affordable, basic health coverage for working citizens who are uninsured with an option for small business participation in employee coverage.

Cover Rx: Expands the Safety Net program for affordable medication to low income, uninsured citizens.

The program also expands an educational pilot project to schools to teach healthy lifestyles and launches a program focused on reducing Type II Diabetes and obesity. The target date for benefit implementation is early 2007.

CoverKids, a health insurance program for children and pregnant women, is scheduled to be the first of the Cover Tennessee initiatives to be implemented. As part of the federal States' Children's Health Insurance Program (SCHIP), CoverKids will be separate from TennCare and could begin enrolling participants by November 1, 2006 with benefits starting as early as January 1, 2007.

Legislative Initiatives and Changes

In addition to the Cover Tennessee Plan, several other pieces of legislation impacting mental health were enacted during the 2006 session that provide for the following:

Public Chapter 619: Substitutes the federal SSI payment standard for the $600 monthly income limit for a resident so that a supportive living facility for the mentally ill may receive support payments for that resident.

Public Chapter 675: Specifies that whenever the education of a child becomes the state's direct responsibility for any reason, the Commissioner of Education shall pay to the state agency responsible for the child or as may be otherwise directed in the general appropriations act, an amount equal to the state education funds, plus the local education funds, which would otherwise be expended on the child had the child not been placed under state care.

Public Chapter 812: Requires DMHDD, in conjunction with community stakeholders, to recommend options for access to non-emergency behavioral health services for individuals in the state who are uninsured.

Public Chapter 846: Allows a person employed by a personal support agency licensed under Title 33, Chapter 2, Part 4, to administer non-injectable medications upon a written waiver of liability signed by the client or such person's authorized representative. Requires that those administering medication receive eight hours of training by a licensed nurse.

Public Chapter 1000: Extends the Department of Mental Health and Developmental Disabilities, which was to terminate on June 30, 2006, by one year or such time as the joint governmental review evaluation committee holds a hearing and the general assembly takes action. Extends the DMHDD Planning and Policy Council, which was to terminate on June 30, 2006, by one year or such time as the joint governmental review evaluation committee holds a hearing and the general assembly takes action.

Senate Joint Resolution 799: Directs the Select Committee on Children and Youth to establish a study committee to develop an interim report describing the mental health needs of children and youth and initial blueprint for a comprehensive system by April 2007 and a full plan for development, implementation and oversight of such a system on or before April 2008.

Regional / Sub-state Program Description

There are currently twenty-two private, non-profit CMHAs providing the bulk of public behavioral health services in Tennessee, including seventeen Community Mental Health Centers (CMHCs) and five specialty providers. These more traditional provider agencies provide services to more than 150,000 adults and children each year at one of more than 250 sites throughout the state.

The majority of these agencies have undergone major restructuring since 1996 to accommodate on-going changes in TennCare enrollment, service mix, reimbursement procedures, contract negotiations with BHOs under the TennCare Partners Program, and with DMHDD for the Mental Health Safety Net in July, 2005.

The recent restructuring of the system of care brought about much stricter TennCare eligibility requirements. These new requirements have made it more difficult to qualify for TennCare benefits, especially for the lower-income, working poor population. As a result, the uninsured population has grown and a larger percentage of consumers presenting at CMHAs for service have no third party resource to help with health care expenses.

The CMHAs are attempting to respond to this dramatic increase in the amount of uncompensated costs that will be accrued in delivering needed behavioral health care services. Although it is too early to determine, the Cover Tennessee programs promise some relief from this added demand on CMHA resources, especially in the area of children and youth services.

With the change of MCOs coming into the Middle Tennessee region to implement a program offering both physical and behavioral health services in an integrated fashion, the CMHAs are preparing for a major shift in the service delivery model and, indeed, the philosophy on which behavioral health care services are based. The new integrated model will need to support transitional efforts to ensure that recovery-based services are available to TennCare-eligible persons. The CMHAs view the awarding of new TennCare contracts with updated deliverables as an opportunity to accelerate the implementation of progressive, recovery-based services throughout Tennessee.

In addition to TennCare, most behavioral health agencies receive other support through the United Way, private fund-raising activities, Employee Assistance Program contracts and other local, county and state grants. However, the percentage of Medicaid (TennCare) dollars has become an increasingly larger portion of agency funding due to the loss of various local and commercial revenue sources.

State Mental Health Agency Leadership

A commissioner heads the State Mental Health Authority. The Commissioner of MHDD is a cabinet-level position and has direct access to the Governor. The Commissioner's Core Team includes the Executive Directors of the Divisions of Administrative Services, Clinical Leadership, Managed Care, Policy and Legislation, Recovery Services and Planning, and Special Populations and Minority Services. Staff in each of these areas provide leadership in service development and participate in collaborative efforts with a number of other federal, state and community partners. (A Department organization chart is included with this application as Appendix 5.)

The Division of Administrative Services oversees contracting and monitoring, information systems and the budget. Clinical Leadership staff, including the Chief Medical Officer, Chief of Pharmacy, and Director of Nursing provide consultations, clinical oversight, best practice guidelines and conduct research reviews.

The Division of Managed Care (DMC) oversees contracting for the TCPP and works closely with the Bureau of TennCare on priority population definition and classification, contract language, enrollment criteria, marketing and educational material development, best practices, data collection and reporting, and adequacy of provider networks.

DMC is currently overseeing proposed contracts for a new carve-in managed health care option for Middle Tennessee. The Department plans a comparative outcomes study of the new carve-in and current carve-out managed care models and has received agreement from the Bureau of TennCare that further moves toward expansion of a carve-in model will not occur until this study is completed and results can be analyzed.

The Division of Policy and Legislation (DPL) works with all program and planning areas to develop departmental policy through legislative initiatives, grant applications, data collection, contracting, program monitoring and service recipient advocacy. DPL oversees adult and juvenile outpatient and inpatient forensic evaluations and the Criminal Justice/Mental Health Liaison Project, working collaboratively with community providers, jails, law enforcement, judges and court officers.

The Division of Recovery Services and Planning oversees the SETH initiative, promoting recovery for persons diagnosed with serious mental illness and co-occurring disorders. Staff provide collaborative leadership with Vocational Rehabilitation, employers, local builders, banks, federal loan corporations, community homeless coalitions, consumer and family support and advocacy organizations and state and local transportation agencies, public and private. The Division also coordinates Departmental planning including state and regional policy and planning councils, the Three Year Plan, Mental Health Block Grant Plan, and policy and contractual services.

The Division of Special Populations and Minority Services develops and monitors a continuum of services across the lifespan, focusing on services for children and youth with or at risk for SED, those with co-occurring disorders of mental health and substance abuse, and older adult populations. The Division also coordinates Title VI activities and works closely with the faith-based community to develop outreach strategies for individuals and families reluctant to access traditional mental health providers.

DMHDD contracts for MHSN services and manages a database of TennCare disenrollees eligible for services, confirming termination from TennCare and overseeing registration. Staff provide claims auditing of the MHSN providers and prepare reports related to registration and audit findings. DMHDD staff prepare a weekly stakeholder update of MHSN registrations and services provided and a report for providers to enable more targeted outreach to disenrollees in their service areas.

When adults with SMI were scheduled to be disenrolled from the TennCare waiver population, the Commissioner of MHDD played an essential role in securing funding for a MHSN program and has successfully advocated to assure that mental health benefits are included in Cover Tennessee health insurance options.

Department staff provide advocacy, planning, service development, program monitoring and evaluation, budget monitoring, and technical assistance for non-TennCare community support programs, forensic services and grant projects. The Department oversees a number of federal grants that support initiatives in data information systems, homelessness, housing, substance abuse, systems of care and suicide prevention.

DMHDD maintains mental health licensing responsibilities, oversight of the forensic services contract for adults and juveniles and PASRR (Preadmission Screening and Resident Review) activities for those persons applying for nursing home admission and thought to have a mental illness or the developmental disability of mental retardation.

The Office of Hospital Services oversees hospital staffing requirements, quality assurance, and community relations for the five state RMHIs. In addition, DMHDD is responsible for investigations at RMHIs and complaint resolution for consumers, family members, legislators, and the public.

The Department identifies, advocates, and plans for adults with SMI and children and youth with SED. DMHDD administrative and other key staff work closely with other service departments to assure the integration of multi-agency funded services to provide appropriate service components that are designed to meet behavioral health needs along a continuum from education and prevention to resiliency and recovery.

VISION: People with mental illness, serious emotional disturbance, or developmental disability have a quality life based on their individual needs and choices.

MISSION: The mission of the DMHDD is to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation and rehabilitation services and supports based on the needs and choices of individuals and families served.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

a) ADULT MENTAL HEALTH SYSTEM

Criterion 1: Comprehensive Community-Based Mental Health Service System

Approximately 139,809 adults received behavioral health services through the TCPP in FY05; a 5.7% increase over FY04. (URS Table 2A) Block Grant and other state and federal funding served 26,365 adults and their families. The medical and behavioral benefits offered under TennCare, combined with the support, recovery and special population initiatives provided with state and federal grant dollars, serve to provide a comprehensive array of community services. In FY05, 94% of adults responding to the adult consumer survey reported positively about access, an increase from 88% in FY04. (URS Table 11a)

There was an overall increase in numbers served in all race and ethnicity categories reported in FY05. (There were no services reported in the Native Hawaiian/Pacific Islander category.) All but the Hispanic category are generally comparable with 2000 census data estimates, although regional differences are not reflected in the aggregate data. Although below the total state census estimate of 2.2%, services to adults identifying themselves as Hispanic increased by over 50% from FY04 to FY05, continuing a significant rise since FY03.

While well below the 12% 2000 census estimate, the number of adults age 65 and over receiving services showed a slight increase in FY05, but remained within the range of 3%-4% of adults served, as it has been for the past four years. Many seniors are reluctant to access services through traditional mental health clinics and may be receiving behavioral health services through primary care physicians or public clinics. DMHDD funds programs targeted to older adults. These programs collaborate with the older adult services community and provide outreach, assessment, in-home peer and professional counseling services, and/or mental health services within community health clinics.

Approximately 91% of adults served were between ages 21 and 64 and 5% between ages 18 and 20. There were no changes in gender patterns, with females comprising 64% of adults served.

There was nearly a 1% decrease in adult psychiatric admissions between FY04 and FY05. Approximately 35% of all psychiatric admissions were to state psychiatric hospitals and 65% to other inpatient facilities; very similar to FY04 with just a slight decrease to RMHIs. (URS Table 3) These figures reflect efforts to decrease inpatient admissions and continue a downward trend since FY03. It was feared that the initial impact of TennCare reform would be reflected in inpatient rates for FY06, but preliminary data does not indicate any significant increase.

Criterion 2: Mental Health System Data Epidemiology

Tennessee uses the federal estimate of 5.4% of the over 18 population as a prevalence rate for adults with SMI; using 2004 figures supplied by CMHS, this results in an estimate of 242,589 adults. (URS Table 1) About 85% of that number were enrolled in the TennCare Program for some time during FY05, either through Medicaid eligibility or as uninsured or uninsurable. The penetration rate has climbed steadily since 1998, but is expected to decline with continued TennCare disenrollment.

During the six-month period of November 2005 through April 2006, the number of priority adult TennCare enrollees steadily decreased in each of the seven mental health planning regions of the state, reflecting TennCare disenrollment. However, adults with SMI still comprise 10% of enrollment, and that percentage has remained generally stable throughout TennCare's history. Some 65.3% of the 139,809 adults receiving services in FY05 were assessed as SMI (91,254); an increase from 62% in FY04. (URS Tables 2A and 14A) Due to TennCare reform, the actual number of adults with SMI served through the TCPP during FY06 will decrease.

Criterion 3: Children's Services – Not Applicable to Adult Plan

Criterion 4: Targeted Services to Rural and Homeless Populations

The state is currently able to report living situation, including homeless status, only for those adults completing the FY05 consumer survey. (URS Table 15) Approximately 2% of 4,370 responders indicated "Homeless/Shelter" for living situation; an additional 10% marked "Other", which might include non-shelter homelessness. Point-in-time counts of the homeless in Tennessee from 2005 indicated some 7,223 persons living unsheltered or sheltered. DMHDD is dependent upon federal support from the Projects for Assistance in Transition from Homelessness (PATH) to provide outreach, referral and case management services to homeless adults. PATH projects in FY05 served slightly less homeless adults than in FY04. PATH and state supplemental funding provides ten projects, five of them serving smaller cities and rural counties.

The percent of rural TennCare enrollees assessed as SMI continues to be consistent with the percent of overall rural population figures with over 90% of rural enrollees receiving behavioral health services. DMHDD conducts monthly audits to monitor the adequacy of the BHOs' provider networks to determine if access to services meet contractual standards. Telemedicine projects allow for improved access to assessment, treatment and specialist consultation in targeted rural areas of the state.

Criterion 5: Management Systems

Department staff continues to remain stable. State psychiatric institutes consistently deal with challenges in recruitment and retention of qualified nursing staff, psychiatrists, and pharmacists. The Department of Personnel completed policy changes that allow for greater flexibility for negotiating starting salaries for these staff classifications. Although challenges remain, resources are adequate to meet the needs of those served.

DMHDD continues to provide for training events for emergency personnel and first responders and partners with the Department of Health in all-hazards behavioral response as part of bioterrorism, mass casualty and pandemic response planning. The DMHDD, MCOs and BHOs provide a variety of training events for community providers.

Strengths and Weaknesses of the System

Strengths of the current system of care for adults include the wide availability of consumer-run education, support and recovery services; the successful interface between criminal justice and mental health; collaborative housing and employment initiatives; administration and staff dedication to transformation goals and a recovery-oriented system; and effective consumer, family and advocacy involvement from local to state levels. Additionally, the quick action taken in developing the MHSN program in response to TennCare reform is indicative of a highly dedicated and flexible administrative staff and involved and active stakeholder groups.

Challenges include developing continued options to provide necessary services to individuals without health care coverage, including continued tracking of adults with SMI disenrolled from TennCare; expansion of transformation activities, monitoring a carve-in managed care system in Middle Tennessee, determining the impact of the implementation of Cover Tennessee, and assuring widespread adoption of a recovery orientation at all levels of state and local service agencies.

Unmet Service Needs

Service needs are identified through an annual needs assessment process with input from all regional and state councils and DMHDD division staff. Requests are reviewed and prioritized for recommended inclusion into the Three Year Plan by the Planning and Budget Committee of the MHDD Planning and Policy Council. This process allows for a broad grassroots forum to advise the Department on the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families and provides citizen participation in the development of the DMHDD annual budget improvement request.

For FY07, DMHDD Council priorities include: 1) televideo capacity at RMHIs to allow evaluation and consultation on persons being assessed as needing involuntary commitment, 2) expansion of criminal justice/mental health liaison project, 3) full funding of the Creating Jobs Initiative, 4) transportation initiatives, 5) co-occurrence services training and coordination, 6) conservatorships for persons requiring oversight to facilitate discharge from inpatient care, and 7) an older adult mental health services directory.

With the recent reform in the TennCare system, further anticipated needs include the development of resource options for those without health care insurance and the continued monitoring and evaluation of MHSN services to adults with SMI disenrolled from TennCare.

Plans to Address Unmet Service Needs

Title 33 of the Tennessee Code Annotated, the mental health and developmental disability law, requires the DMHDD to develop a Three Year Plan based on the DMHDD Planning and Policy Council recommendations. The plan must be updated at least annually, based on an assessment of the public need for mental health and developmental disability services and supports. The Department's improvement budget request is tied to the annual update of the plan.

The FY07 budget request included the following service initiatives for adults:
- Continuation of Housing Within Reach grant initiatives with four consumer housing specialist positions
- Expansion of criminal justice/mental health liaison project by four liaison positions
- Seed funding for the Creating Jobs Initiative
- Seven Peer Support Recovery Specialist positions

Of these requests, the four consumer housing specialists were fully funded and the Creating Jobs Initiative was partially funded in one area due to local advocacy efforts.

New Freedom Commission goals form the framework of the Three Year Plan. The Department modified goals to include persons with developmental disabilities to develop objectives and strategies that will assist the Department in planning integrated services and supports essential to persons with mental illness, serious emotional disturbance or developmental disabilities. Strategies for FY07 in the Three Year Plan related to unmet service needs identified by staff and stakeholders for adults include:

Strategy 2.2.4: To seek grant opportunities to increase availability of conservators for individuals with mental illness or developmental disabilities who live or are proposed to live in the community.

Strategy 3.2.20: To assist, through the Older Adult Projects, in developing a statewide directory of mental health and substance abuse services for older adults, which will be made available on the Department's website.

Strategy 4.2.1: To collaborate with the DOH, BADAS, to share information and plan interdepartmental activities to address the integrated screening, assessment and treatment/service needs of persons with co-occurring disorders of mental illness and substance abuse/dependence.

Strategy 5.1.10: To complete a point in time study for service recipients engaged in the criminal justice system to determine the influences on the person at the time of their encounter with law enforcement leading to the arrest and the relationship among those influences.

Strategy 5.3.20: To provide community mental health and employment stakeholders up-to-date employment services education, one-on-one grant preparation training, consultation and exploration of access to matching public and private funds.

Despite limited funding, the CJI has moved forward, expanding the role of existing SETH facilitators and accessing a group of Vista volunteers, who are all mental health consumers, to further employment initiatives.

Strategy 5.3.22: To work in partnership with state and local transportation authorities to plan for and expand transportation options for people with mental illness, serious emotional disturbance or developmental disability.

Strategy 6.1.19: To promote, expand and monitor the efficiency and effectiveness of televideo services through the entire mental health delivery system with an emphasis on an interface with primary care providers and forensic evaluations.

The current Three Year Plan is available for review on the DMHDD website at http://www.state.tn.us/mental/overview/html – link on banner to the left.

Summary of Significant Achievements Reflecting Progress Toward the Development of a Comprehensive Community-based Mental Health System of Care

Achievements in FY06 that reflect development of a more comprehensive system of care for adults include:

- The MHSN service package was developed and implemented to provide continuity of necessary services for adults with SMI who were disenrolled from the TennCare waiver population.
- Housing options continue to grow through the Creating Homes Initiative (4,468 new or improved units of housing and $101,859,259 in leveraged funding as of 11/05). New awards in FY06 include the Federal Home Loan Bank of Cincinnati, HUD Continuum of Care, and Tennessee Housing Development Agency HOME grants.
- A Creating Jobs Initiative has begun in collaboration with state Vocational Rehabilitation and seven mental health consumer VISTA volunteers to create increased employment opportunities for individuals with SMI.
- Attained a grant through the federally funded PATH program to provide technical assistance to determine the feasibility of a housing first/employment first strategy to end chronic homelessness in Knoxville, Memphis and Nashville.
- The criminal justice/mental health initiative provided training for TBI officers across the state and are completing *Mental Health in Tennessee Courts*, a process manual for Judges, Defense Attorneys and District Attorneys.
- Established a clinical televideo service at one RMHI as a pilot. Seeking funding to implement at all five state psychiatric facilities.
- Piloted TN-MAP, the Tennessee Medications Algorithm Project, with one RMHI and its community providers with plans to implement at all five state psychiatric facilities.

Brief Description of the Public Mental Health System Envisioned for the Future

There are many variables that have and will continue to impact the future public mental health system. The most significant of these include:

- Continued disenrollment from TennCare. Some persons are still involved in an appeals process, some have qualified for Medicaid and been recertified, and some have been officially disenrolled.
- The adequacy of Medicare Part D for the approximately 97,000 dual eligibles (Medicare and Medicaid) no longer eligible to receive outpatient medications through the TennCare program.
- Continued services to over 26,000 adults currently eligible for MHSN services.
- The financial future of DMHDD-funded inpatient and outpatient services for persons meeting certain criteria for state only or judicial coverage.
- Full loss of the Medicaid IMD (Institutions for Mental Diseases) exemption for state and private psychiatric hospitals.

- The impact of the new carve-in managed care treatment model contract for the Middle Tennessee area.
- Implementation of the Cover Tennessee Plan, signed into law in June 2006, designed to increase health care access for uninsured Tennesseans.

DMHDD has been and will remain integral to the planning, implementation and monitoring of these significant events in the continuing evolution of the behavioral health care system.

We envision the best possible outcomes for those we serve with continued goals of decreased stigma, increased use of evidenced based practices, and a continuum of consumer driven recovery services.

SECTION III. PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

a) ADULT PLAN

Establishment of a System of Care

Within the Tennessee Code Annotated, Title 33, Chapter 2, Part 1, DMHDD authority and responsibilities are defined as below:

Community Service System
The department shall plan, coordinate, administer, monitor, and evaluate state and federally funded services and supports as a community-based system within the total system of services and supports for persons with mental illness, serious emotional disturbance, developmental disabilities, or at risk for such conditions and for their families. All functions shall be carried out in consultation and collaboration with current or former service recipients, their families, guardians or conservators, service recipient advocates, service providers, agencies, and other affected persons and organizations.

(a) Within the limits of available resources, it is the goal of the state to develop and maintain a system of care that provides a comprehensive array of quality prevention, early intervention, treatment, habilitation and rehabilitation services and supports which are geographically available, equitably and efficiently allocated statewide, allowing people to be in their own communities in settings, based on the needs and choices of individuals and families served.

(b) The state's purposes are to:

(1) Establish and sustain a broad range and scope of flexible services and supports across the domains of residential living, working, learning, community participation, and family support including crisis, respite and other emergency services, which help service recipients maintain respected and active positions in the community, and

(2) Promote the early identification of children with mental illness, serious emotional disturbance, developmental disabilities, and developmental delay to assure that they receive services and supports appropriate to their developmental level and changing needs.

(c) The general assembly finds as facts that the needs of persons with mental illness, serious emotional disturbance, and developmental disabilities cannot be met by the department in isolation and that such persons need to receive services and supports that are integrated, have linkages between and among other human service agencies and programs, and have mechanisms for planning, developing, coordinating, and monitoring services and supports to meet their needs.

1) Current Activities – Adult Plan – Available Services

i. Criterion 1 A Comprehensive Community-Based System of Care

Mental Health Services: Currently, the TennCare benefits package includes the following services.

- Inpatient Psychiatric Treatment
- Outpatient Mental Health Services
- Inpatient, Residential and Outpatient Substance Abuse Treatment Services (except Methadone)
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Psychiatric Rehabilitation Services
- 24/7 Crisis Response Services and Crisis Respite

Mental Health Safety Net Services: Available to adults assessed as SMI disenrolled from the TennCare waiver population.

- Assessment, Evaluation, Diagnostic, and Therapeutic Interventions
- Case Management
- Psychiatric Medication Management
- Laboratory Services Related to Medication Management
- Pharmacy Assistance and Coordination

In addition to the above behavioral health benefit packages, the following services are available within the comprehensive array of community services:

Health – Public Health

DMHDD staff and community providers participate in statewide depression screening activities at state and local events. Supported Living Facilities must provide or procure for each service recipient an annual physical examination, which includes routine screening and special studies as determined by the examining physician. Individuals hospitalized under involuntary emergency status receive physical examination within twenty-four (24) hours of admission.

The Department of Health provides protective flu and pneumonia vaccines for residents of all nursing homes, assisted living facilities, and homes for the aged and disabled and local health departments provide a variety of screening services free of charge to eligible individuals including, but not limited to, screening for breast and cervical cancer and communicable diseases.

As part of the State's overall safety net service package, public health clinics received improvement dollars to expand the provision of medical services to individuals without health care insurance.

Employment Services: Vocational programs are available at eighteen Psychosocial Rehabilitation Service programs across the state. Services may include, but are not limited to, supported employment, pre-vocational work units, work assessments, job readiness training, and work enclaves. Employment services are also available directly from the Department of Human Services, Division of Vocational Rehabilitation. The Creating Jobs Initiative has begun work through seven regional consumer Vista volunteers to develop employment opportunities for persons with mental illness with a goal of 2010 new jobs by 2010.

Rehabilitation Services: For individuals not able to or not desiring to work, psychosocial programs and Peer Support Centers provide skill building, promote independent living capabilities, offer peer counseling and provide educational and social rehabilitation opportunities.

Housing Services: DMHDD supports forty agency-operated HUD group homes and supported living apartments, six assisted living sites and provides supplemental funding for utilities and rent to assist consumers with SMI to maintain housing of their choice. Tennessee's Creating Homes Initiative develops housing options and assists adults with SMI in finding appropriate housing based on their needs and desires.

Educational Services: GED classes and other educational activities are available at Psychosocial Rehabilitation programs and at many of the Peer Support Centers across the state. Adults, aged 18-22, who are still attending school may also be served under the Individuals with Disability Education Act by the Department of Education.

Medical and Dental Services: Primary care physician and specialist medical services are provided under TennCare and by various community health clinics, emergency clinics, and hospitals. Two Mental Health/Primary Care integration projects provide an integrated model of assessment and treatment. A portion of independent living assistance funds are available to community providers to access needed medical and/or dental care for priority population adults.

Substance Abuse Services: Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of the BHOs and the DOH, BADAS. Many of these contract agencies are CMHAs. The Access to Recovery (ATR) Program, a three-year federal grant, provides service vouchers to expand access to substance abuse treatment through a variety of local providers.

Case Management Services: Mental Health Case Management Services are a benefit of the TennCare Partners Program. Case managers serve as the agent for linking, facilitating, and monitoring the receipt of direct services and supports. An assessment process provides for measurements of intensity and duration needed and proposed objectives to be met in the service plan. The BHOs have documented policies regarding caseload capacities and expected consumer outcomes.

Services for Co-occurring Disorders (COD): DMHDD funds Foundations Associates to promote and develop integrated services for adults with COD at agencies across the state. The grant also supports a transitional housing program and the Dual Diagnosis Recovery Network (DDRN), which promotes addiction education and develops Dual Recovery Anonymous support groups statewide. While not exclusively for consumers with COD, Foundations supports a Peer Support Center and provides independent living subsidies.

The Co-occurrence Project, a joint effort of DMHDD and the DOH, BADAS, supports nine case management projects across the state for individuals with co-occurring disorder without insurance or ability to pay for services. Case management staff have experience in both mental health and substance abuse services and provide services within an integrated treatment setting.

DMHDD is also a recipient of a three-year federal grant to coordinate substance abuse services for individuals abusing methamphetamine in Southeast Tennessee.

Services for Special Populations: DMHDD supports the following service initiatives for those with special needs:

- Two Program for Assertive Community Treatment (PACT) teams in Knoxville and Nashville.

- Services for Older Adults: Four projects offer outreach professional mental health counseling and other support services to adults age fifty-five and over who are homebound or do not access traditional outpatient mental health services. In addition, a three-year CMHS grant supports the initiation of statewide mental health aging coalitions. A three-year CSAT grant is developing a culturally competent, flexible and comprehensive continuum of care for adults aged 55+ who have mental health needs and are abusing alcohol or other drugs in the Greater Nashville Area.

  DMHDD contracts for and oversees the PASRR process for individuals in nursing homes or seeking nursing home admission who have a mental illness or a developmental disability. Since FY03, there has been a steady but slight increase in preadmissions screenings.

- Services for Consumers Interfacing with Criminal Justice System: Criminal Justice liaison staff provide early identification of persons with SMI or COD within the criminal justice system, promote diversion alternatives to community programs, and provide training and education to enhance collaborative efforts between the criminal justice and mental health systems. Currently, there are eighteen criminal justice projects covering twenty-three counties.

- Deaf and Hard of Hearing: This population is included in cultural competence efforts and DMHDD staff participate in meetings of the Tennessee Council for the Deaf and Hard of Hearing. All Mental Health Planning Council meeting announcements contain special accommodations information and interpreters are provided as needed. The BHOs require contract providers to assure interpreters as needed.

Support Services: DMHDD assists in funding the following support services:

- TMHCA consumer support groups across the State, including the consumer-taught education class, BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support).

- Thirty-four NAMI-TN affiliates provide support services for family members and caregivers of persons with psychiatric disorders, including the development of Journey of Hope (JOH) educational classes.

- The TN Suicide Prevention Network oversees a statewide suicide prevention hotline, survivor support groups, and staff training in suicide prevention.

- Peer Support Centers provide self-directed recovery opportunities targeted toward illness management and community reintegration.

Activities to Reduce Hospitalization:

- 24-Hour Walk-in Assessment and Triage, Chattanooga and Nashville: Crisis service staff are on site and provide evaluation, medication, and counseling services.

- Crisis Stabilization Unit, Chattanooga: Provides triage, referral and stabilization services for medically stable adults who present in a psychiatric crisis and are assessed as needing a level of care greater than respite but less than inpatient psychiatric hospitalization.

- Targeted Transitional Support: Assists persons eligible for discharge from the RMHIs to move to community settings with temporary transitional support until their financial benefits/resources are established.

- Mandatory Prescreening Law: A pre-screening evaluation for eligibility for emergency involuntary admission to RMHIs. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis.

- Mobile Crisis Response Services: Crisis response services are available 24/7 in every county in Tennessee. Approximately 43% of adult face-to-face contacts result in diversion from an inpatient setting.

All services under Criterion 1 have been implemented. A continuing theme of recovery increases the focus of provider training and ensures the development of outcome measures to indicate consumer movement toward their goals.

Transformation Activities: (Goal numbers correspond to goals and recommendations in a transformed mental health system as recommended by the President's New Freedom Commission on Mental Health report.)

Goal 1.1: Advance a campaign to reduce the stigma of seeking care and a strategy for suicide prevention.

In 2006, the Commissioner of MHDD launched the "Overcoming Stigma Campaign", a multi-year project to educate the public and increase awareness of the impact and cost of untreated mental illness in order to remove financial and bureaucratic barriers to treatment. Target audiences will be representatives from businesses, insurers, chambers of commerce, mental health associations, city/county leaders, governments and consumer/family stakeholders. The focus for 2006 is community business leaders.

The TN Suicide Prevention Network is an independent, non-partisan, voluntary group of individuals, organizations and agencies (public and private) who promote community awareness of the signs of suicide and intervention strategies for the prevention of suicide. The network's goals are to coordinate and implement the Tennessee Suicide Prevention Strategy, which builds on the fifteen points raised in "The Surgeon General's Call to Action to Prevent Suicide," published by the Department of Health and Human Services, Washington, D.C., 1999. Further information may be found at www.tspn.org.

Goal 2.1: Develop an individualized plan of care.

DMHDD licensure rules require that an Individual Program Plan be developed for each client, based on an initial history and ongoing assessment, with documentation of service recipient participation in the treatment planning process. In the 2005 consumer survey, 89.4% of adults responded positively about their participation in treatment planning.

Over half of the forty-nine Peer Support Centers across the state work with consumers to develop their own Wellness Recovery Action Plan (WRAP), a structured system to monitor symptoms, carry out planned responses and determine treatment and support needs and choices for when symptoms have made it impossible to make those decisions. WRAP enables consumers to develop a blueprint for personal recovery and self-management that incorporates wellness tools and strategies into their lives.

Tennessee mental health and developmental disability law supports a Declaration for Mental Health Treatment document for service recipients, age sixteen or over, to describe what they want to occur when they receive mental health treatment. A Declaration for Mental Health Treatment allows persons receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

Goal 2.2: Involve consumers and families in orienting the mental health system toward recovery.

As a direct result of consumer and family feedback regarding a new contract for managed care services for Middle Tennessee, DMHDD recently published "Managed Care Standards for the Delivery of Behavioral Health Services", which states: "All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance abuse issues." Definitions of recovery and resiliency are based on the 10 Fundamental Components of Recovery and on the System of Care Values and Principles endorsed by SAMHSA and CMHS.

Goal 5.2: Advance evidenced-based practices using dissemination and demonstration projects.

DMHDD implemented a medication algorithm pilot project, Tennessee Medication Algorithm Project (TNMAP), at Western Mental Health Institute with support from local community mental health agencies for service recipients diagnosed with schizophrenia. In FY07, plans are to expand the TNMAP project to all RMHIs, with support of local community mental health agencies.

ii. Criterion 2 Mental Health System Data Epidemiology

Tennessee utilizes the federal definition for its adult priority population: "An individual age eighteen and over who currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual that has resulted in functional impairment that substantially interferes with or limits one or more major life activities." The degree of functional impairment is rated by using a Clinically Related Group (CRG) assessment form. Assessments are done by DMHDD approved raters from authorized CMHAs and RMHIs.

The assessment is based on diagnosis, severity of impairment in four domains (Activities of Daily Living; Interpersonal Functioning; Concentration, Task Performance and Pace; and Adaptation to Change), duration of impairment; and need for services to prevent relapse. A rating of 1-5 is assigned to an adult. Those with a CRG rating of 1, 2, or 3 are considered either SMI or SPMI, based on duration and severity of impairment, and are included in the mental health adult priority population.

DMHDD will utilize CMHS estimates of prevalence for the number of persons with SMI from URS Table 1. The population and prevalence estimate is based on 5.4% of the state population of individuals age 18 and over. The prevalence estimate based on 2004 Census data for Tennessee for adults age 18 and older is 242,589. The annual penetration rate is defined as those adults identified as SMI and enrolled for any period of time in TennCare during the fiscal year; for FY06 that number was 196,858 for an 81% penetration rate.

Preliminary data for FY06 show that, as expected, the number of adults served through the TennCare Partner's program has decreased following waiver population disenrollment, showing an overall decrease of nearly 26% in the number of adults served, including a 23% decrease in the number of adults with SMI served. MHSN services were provided to approximately 56% of adults with SMI reflected in the disenrolled population, decreasing the overall reduction in adults with SMI served to 10.4%.

During FY07, DMHDD community contracts are expected to provide direct services and supports to over 26,300 unduplicated adults and family members; over 11,000 of them through Block Grant funded initiatives. Further quantitative goals are included in the Adult Goals, Targets, and Action Plan section for Criterion 2 on page 44.

iii. Criterion 3 (Not applicable to Adult Plan)

iv. Criterion 4 Targeted Services to Rural and Homeless Populations

Homeless

The TCPP provides a continuum of services for all eligible individuals with SMI. Homeless persons who meet the eligibility criteria may receive TennCare using agency addresses, shelter addresses, or Post Office boxes. Homeless persons who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost consumer and family support groups and Peer Support Centers at various locations throughout the state.

DMHDD is largely dependent upon federal PATH grant support to provide outreach and case management services to homeless adults. PATH has expanded from the four original urban programs to a total of ten projects, five of them serving smaller cities and rural counties. In addition to the PATH program, there are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. The sites are located in three urban areas: Chattanooga, Nashville, and Knoxville.

In FY07, these three sites will be recipients of a technical assistance grant to determine the feasibility of a housing first/employment first strategy to end chronic homelessness.

Chattanooga has two sites with housing capacity of sixteen adults. Nashville has four sites with housing capacity for fourteen adults. The regional SETH facilitators work closely with PATH programs to develop housing options for adults with SMI or COD who are also homeless. The state provides supplemental dollars to assist agencies in PATH and permanent housing projects.

An opportunity presented itself to DMHDD through participation with the Governor's Interagency Council on Homelessness. Division of Recovery Services and Planning staff will be participating in the SOAR (SSI/SSDI Outreach, Access, and Recovery) project for improving access to mainstream services for people experiencing chronic homelessness. SOAR is a train-the-trainer technical assistance initiative designed to increase access to government benefits for homeless people with disabilities, including those with serious mental illnesses and co-occurring disorders. The project utilizes the SAMHSA-developed *Stepping Stones to Recovery* curriculum in an effort to help case managers assist homeless adults with the application process for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

Rural

DMHDD defines a “rural county” as one that has 50% or more of its population in a rural area and is not included in the Metropolitan Statistical Areas list. Using this definition results in fifty-nine of ninety-five counties meeting the criteria for rural. This information is obtained from the 2003 Tennessee Statistical Abstract.

The TCPP policies require equal eligibility, service coverage, and availability statewide to both urban and rural Tennessee residents. TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations. Non-clinical service initiatives like Peer Support Centers and consumer support groups are located in rural areas with transportation provided for access.

A critical issue for rural residents is their ability to access medical or mental health specialists. Several rural-based CMHAs participate in the federal rural recruitment and retention plan to hire psychiatrists and psychologists.

In addition, forty-two telemedicine sites have the capacity to provide increased access and availability to physician services for those living in rural areas where Tennessee has the greatest psychiatrist shortages. Staff monitor telehealth access through review of agency requests and encounter data. The BHOs educate providers on the appropriate utilization of telehealth and promote and encourage its use.

Rural service planning must also take into account the routine travel patterns of rural populations for other services (e.g., shopping, banking, recreational, etc.) to provide convenient access to behavioral health services.

The DMHDD Division of Managed Care maintains geoplots of BHO service providers and monitors geographical access to emergency, urgent and routine care. However, geographical access may not always equal actual access due to provider capacity. When disparities occur, the issue then becomes a point of contract negotiation for provider expansion in a needed area.

Transformation Activities: (Goal numbers correspond to goals and recommendations in a transformed mental health system as recommended by the President's New Freedom Commission on Mental Health report.)

Goal 3.2: Improve access to quality care in rural and geographically remote areas.
During FY07, DMHDD staff will meet with rural hospitals that currently provide inpatient psychiatric services to explore the possibility of increasing bed capacity to serve TennCare enrollees in rural areas within their home communities.

Goal 6.1: Use health technology and telehealth to improve access and coordination of mental health care, especially for remote areas or underserved populations.
DMHDD promotes state of the art diagnostic systems such as telemedicine to increase response time for diagnosing patients, reduce stressors on the persons with a potential mental illness, and eliminate transportation costs.

A pilot project using televideo for assessments for involuntary emergency admissions is in place at one state psychiatric hospital to promote access to inpatient services for those for whom a less restrictive alternative is unsuitable, to coordinate the admissions process, and to eliminate unnecessary travel, time and stress for consumers, family and law enforcement.

v. Criterion 5 Management Systems

Resources for Providers
Tennessee made available $405,336,429 in capitation payments made monthly to the BHOs for services provided to TennCare Partners Program enrollees through June 30, 2006.

The State continued the financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees that it assumed as of July 1, 1999. The pharmacy cost for individuals for FY06 in the community amounted to $367,363,853 with medications for individuals during inpatient stays included in the inpatient rates received by the respective inpatient facilities. The pharmacy cost was significantly reduced from the previous year due to TennCare reform, which implemented a five prescription limit, a new Preferred Drug List, and the impact of the Medicare Part D program.

The cost of providing forensic and court-ordered evaluations performed at the five RMHIs and in the community is estimated at $24,764,836 dollars.

DMHDD funded community mental health services, excluding forensic and court ordered evaluations, at $30,836,245. This funding includes the CMHS Block Grant award and other federal grants received by the DMHDD.

Further, the five RMHIs expended $99,981,766 above revenue received to provide inpatient mental health services, a 41% increase over FY05.

In total, roughly $928,283,129 was directed for the provision of mental health services to individuals within Tennessee for FY06. The level of funding for mental health services in FY07 may be affected by Medicaid reform.

DMHDD enters into grant agreements to provide a mental health safety net service package to priority population adults who lost TennCare benefits and other service initiatives outside the scope of services provided under the TCPP. Funds are administered through individual grants with CMHAs and other agencies, various Delegated Purchase Authorities for specific services, and additional interdepartmental funds made available to supplement federal grants awarded to Tennessee.

Staffing
DMHDD employs approximately 2,800 staff, 185 in Central Office and the remainder in the five state psychiatric hospitals for approximately 942 hospital beds.

The state contract with the medical and behavioral health organizations requires those entities to maintain an adequate provider base to provide services to individuals covered under the benefit plan. The managed behavioral health care outpatient network currently consists of around 1,200 credentialed and contracted individual and group providers, exclusive of individual CMHA staff.

Additional resources for adults include:
17 providers of 24-hour residential treatment at 66 locations
29 providers of inpatient psychiatric services at 32 locations
21 providers of inpatient substance abuse services at 26 locations
13 providers of crisis response services in 95 counties

Training
BHO consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee's managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires BHOs to offer the following:
1) an educational plan for providers formulated with input from the BHO Advisory Board; (Boards must have minimum 51% family and consumer membership and consumers and family members must be included as trainers.)
2) cross-training of mental health and substance abuse providers;
3) mental health training for primary care providers; and
4) assurance that providers are appropriately licensed, certified, accredited, approved and/or meet DMHDD standards, whichever is appropriate.

DMHDD provides routine training for mandatory prescreening agents, mandatory outpatient providers, forensic evaluators, Peer Support Center directors, PATH provider agencies, and criminal justice liaison staff.

In addition to routine networking opportunities and technical assistance, DMHDD sponsors, supports, or provides a variety of training related to implementation of grant-funded services to community providers, family and consumer groups, and special grant recipients.

Training Providers of Emergency Health Services
Under the TCPP, mental health staff of crisis response services are in regular contact with providers of emergency health services. Crisis services are funded by the BHOs and are available to emergency health staff twenty-four hours a day, 365 days a year.

Crisis staff provide on-going consultation and information on mental health crisis intervention strategies and service alternatives. DMHDD provides training in mandatory pre-screening to eligible mental health professionals. Criminal Justice/Mental Health liaisons provide training in mental health to law enforcement and court officers across the state.

DMHDD provides for Critical Incident Stress Management training courses in each grand region of the state on an annual basis, including sponsoring scholarships for first responders to attend needed courses through International Critical Incident Stress Management Foundation conferences.

The DMHDD Emergency Services Coordinator (ESC) provides presentations on all-hazard mental health interventions to local community civic organizations, county CERT (Community Emergency Response Team) volunteers, and trains community behavioral health staff and other paraprofessionals during times of disaster.

ESC and CMHA emergency response staff participate with other agencies conducting all-hazards preparation, response, and mitigation activities, including the Department of Health on bioterrorism, mass casualty and pandemic response plans and training.

With the assistance of a three year federal grant, the University of Tennessee at Knoxville offers a Master's Degree in Homeland Security Nursing. The program is designed to prepare nurses to respond to mass casualty events and to prepare in advanced clinical nursing assessment and treatment practices for the types of injuries seen in severe natural disasters, bombings, or bioterrorist events.

Transformation Activities: (Goal numbers correspond to goals and recommendations in a transformed mental health system as recommended by the President's New Freedom Commission on

Goal 3.1: Improve access to quality care that is culturally competent.
Strategies for FY07 in the DMHDD Three Year Plan include pursuing non-standard methods for recruiting culturally competent employees and providing training in cultural competence for consumer transportation agents.

Goal 5.3: Improve and expand the workforce providing evidence-based mental health services and supports.
Strategies for FY07 in the DMHDD Three Year Plan include:
- In collaboration with TennCare, to stay current on the most effective mental health treatments and revise Best Practice Guidelines as research indicates.
- In partnership with Technical Assistance Contractors (Advocates for Human Potential and the University of Pennsylvania Collaborative on Community Integration), to provide training on evidence-based employment practices (supported employment and illness management) to providers in Region VII as part of a pilot project.

Goal 5.4: Develop the knowledge base in understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
DMHDD advocates for focused curricula in medical schools and other clinical professional programs in colleges and universities on the identification and treatment of individuals with mental illness, developmental disabilities, and co-occurring disorders.

In FY07, the DMHDD Division of Clinical Leadership will participate in the Tennessee Interdisciplinary Health Policy Program by providing monthly internships for medical, law and pharmacy students to participate as a group in government agency sponsored service to learn the value and effectiveness of the multi-disciplinary approach to health care policy development.

Goal 6.2: Develop and implement integrated electronic health record and personal health information systems.
Strategies for FY07 in the DMHDD Three Year Plan include:
- To implement a new pharmacy software system to interface with Avatar Health Information System (AHIS) for demographic information.
- To study the electronic health record and personal health information systems used in other states and the strategies used to transition to electronic health information systems.

DMHDD is creating an integrated system that standardizes processes and provides for automation to improve staff efficiency and allow more time for direct care delivery to service recipients. The expanded use of video conferencing capabilities in partnership with other State agencies will provide greater access to services. A true electronic medical record will allow a quick exchange of information with other entities, particularly with the community mental health agencies, to create a more seamless continuum of care.

Expenditure of 2007 Block Grant Allocation
CMHS has advised that the 2007 Block Grant Plan use projected allocations based on the final 2006 award amount, or $7,994,515 for Tennessee. Ninety-six percent (96%) of the total award will be granted to community based programs in accordance with the expectations of the block grant. Approximately 4% of the award, or $343,015, supports administrative functions relative to the community mental health system and Mental Health Planning and Policy Councils' support and activities.

DMHDD utilizes its Block Grant funding for the provision of non-clinically related mental health services for adults with SMI and children and youth with, or at risk for, SED. Services are designed to reduce the use of hospitalization; promote education, prevention, and early intervention; integrate services; and build a reliable community support service system that emphasizes empowerment, recovery, and community reintegration for individuals and families.

Currently, fourteen private, not-for-profit CMHCs and five other community agencies receive federal mental health block grant funds to provide services to adults. Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.)

Some $5,167,300 of CMHS Block Grant funding is projected to be allocated for adult services in accordance with Criterion 1, 2, 4 and 5 in the following manner:

Assisted Living Housing $ 210,000
Assisted living fills the gap in the continuum of housing available for adults with SMI who do not require the supervision of a Supportive Living Group Home, but do not yet possess the necessary skills for independent living. The programs consist of clustered apartment units, with one unit occupied by a live-in "assisted living specialist". The specialist is a consumer whose role is to serve as a mentor to and provide support for the other residents. The goal is to assist the consumer in a smooth transition to independent living. Funds support six assisted housing projects.

Criminal Justice Project $ 476,000
Projects provide activities targeted toward individuals with SMI or co-occurring disorders interfacing with the criminal justice system. Services include liaison/case management services, diversion activities, cross-training and education, and appropriate referral and linkage to follow-up services in the community. Goals are to enhance systems collaboration and cooperation, decrease recidivism, and ensure access to appropriate services. Block Grant funds, supplemented by $373,600 in state funding, provide eighteen projects serving twenty-four counties.

Consumer Support / BRIDGES $ 226,500
Funds are provided to the TN Mental Health Consumers Association (TMHCA), via the Tennessee Disability Coalition, to support regional advocacy staff and on-going development of the BRIDGES educational program for mental health consumers.

Cultural Competency $ 21,800
Cultural and linguistic competency promotion is targeted for mental health agencies, mental health providers, and mental health interpreters.

Older Adult Project $ 280,000
The projects provide professional mental health counseling and peer counseling to adults age fifty-five and over who are homebound or otherwise unable or unwilling to access traditional mental health services. Services may be offered in the individual's home or at a primary care site accessed by older adults. Staff either provide or refer individuals to the appropriate level of mental health services. Services are provided in collaboration between a CMHC and the aging community service system. Funds support four programs.

Peer Support Centers (PSC) $ 3,953,000
A PSC is a place where persons who have received treatment for mental illness develop their own programs to supplement existing mental health services. Members address issues such as social isolation and discrimination and provide opportunities for socialization and personal and educational enhancement. PSCs conduct recovery-based services and programs that promote the involvement of consumers in their own treatment and recovery, and assist the consumer in acquiring the necessary skills for the utilization of resources within the community. Funds, supplemented with $672,160 state dollars, support forty-eight programs serving eighty-one of ninety-five counties.

Appendix 6 details the proposed 2007 Block Grant allocations for adult services by agency and program.

2) Goals, Targets and Action Plans – Adult Services

Criterion 1: Comprehensive, Community-Based System of Care

Goal 1.1. To assure effective inpatient treatment and continuity of care to maximize community tenure.

Name of Performance Indicator: Inpatient Readmission – 30 Days
Criterion: 1 – Adult URS Developmental Table 20A
NOM ☑Yes ☐No Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	10.99%	10.86%	11%	10.55%	
Numerator	807	800			
Denominator	7344	7365			

Target: Decreased rate of readmission to acute care state psychiatric hospitals within 30 days of discharge.

Population: Persons 18 and above discharged from state psychiatric inpatient service during FY06.

Indicator: Percentage of adults discharged from inpatient services that are readmitted within 30 days.

Measure: % Numerator: Number of persons age 18+ who are readmitted to a state hospital (RMHI) within 30 days of discharge.
Denominator: Number of persons age 18+ discharged from a state hospital (RMHI) during the previous fiscal year.

Source: DMHDD, Division of Managed Care, Research and Analysis Group
DMHDD, Office of Hospital Services

Issues: Readmission is defined as admission to any RMHI within 30 days of a discharge from any RMHI.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the effectiveness of inpatient treatment and the continuity of community care.

Action Plan

A DMHDD study of hospital readmissions found the most prevalent reason to be the discontinuance of medications. For those for whom hospitalization is the most appropriate option, successful community tenure is impacted by early discharge planning and the timely availability of less restrictive alternatives.

For those enrolled in the managed care program, BHO standards of care require case management assessment for individuals being discharged from inpatient care with a case manager face-to-face encounter within seven days and routine outpatient services available within fourteen days. Outpatient providers are required to maintain access logs of initial appointments and performance is monitored by both the BHOs and DMHDD Division of Managed care.

State psychiatric hospitals are the only inpatient option available for persons without health care insurance. Due to timely implementation of the mental health and public health safety net provisions, including pharmacy assistance, prescription benefit reductions and loss of health care insurance have not appeared to have significantly affected inpatient rates at this time.

Goal 1.2. To provide effective continuity of care and outpatient services and supports that maximize community tenure.

Name of Performance Indicator: Inpatient Readmission – 180 Days
Criterion: 1 – Adult URS Developmental Table 20A
NOM ☑Yes ☐No Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	22.53%	21.34%	21.00%	21.00%	
Numerator	1655	1572			
Denominator	7344	7365			

Target: Decreased rate of readmission to state psychiatric hospitals within 180 days of discharge.

Population: Persons 18 and above discharged from psychiatric inpatient service during FY06.

Indicator: Percentage of adults discharged from inpatient services in FY06 that are readmitted within 180 days.

Measure: % Numerator: Number of persons age 18+ who are readmitted to a state hospital (RMHI) within 180 days of discharge.
Denominator: Number of persons age 18+ discharged from a state hospital (RMHI) during the previous fiscal year.

Source: DMHDD, Division of Managed Care, Research and Analysis Group
DMHDD, Office of Hospital Services

Issues: Readmission is defined as admission to any RMHI within 180 days of a discharge from any RMHI.

Significance: While serious mental illnesses often require hospitalization for necessary adjustments or life crises, a major outcome of a comprehensive, community-based mental health system of care is the ability to provide necessary services in the least restrictive environment.

Action Plan

For those with long term hospitalization, a Targeted Transitional Support Program assists in attaining and maintaining discharge from the state psychiatric hospitals by providing temporary transitional support until their financial benefits/resources are established.

For adults with a history of repeated rehospitalization with minimal community tenure, intensive long-term support services were developed in the Chattanooga area designed to maintain discharged service recipients in the community in supportive living facilities.

Funds are provided for a wide variety of services and supports that complement existing services funded by various departments of the state, which have not sufficiently been able to meet the individual specialized needs of these persons. This intensive, creative and collaborative project has greatly increased the community tenure of a difficult and vulnerable population.

Individual WRAP and crisis intervention plans are also used to promote the early intervention of adequate treatment and support services to avoid the need for rehospitalization.

Goal 1.3: To provide behavioral health services that are rated positively by service recipients.

Name of Performance Indicator: Client Perception of Care/Outcomes
Criterion: 1 – Adult URS Basic Table 11a
NOM ☑Yes ☐No Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	67%	81%	80%	80%	
Numerator	883	3750			
Denominator	1,314	4646			

Target: To maintain a rating of 80% of adults who report positively about service outcomes.
Population: Adults receiving public mental health services.
Indicator: Percentage of adults submitting a positive survey response on outcomes.
Measure: % Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.
Denominator: Total responses reported in the outcome domain on the adult consumer survey.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: None
Significance: A positive perception of care increases the likelihood of continued service acceptance and positive movement toward recovery.

Action Plan:
The highest goal of any service system is to attain the best possible outcome for the service recipient. Since FY02, the percentage on the positive outcome measure has ranged from 64% to 67%. Prior to 2005, the survey was mailed out to a stratified sample and yielded a 23% response rate.

In FY05, DMHDD made a decision to no longer use the mail out method to conduct consumer surveys. A paper survey was given to any willing service recipient with a scheduled appointment at any of twenty-two CMHAs within a twenty-day period. This significantly increased both the number of surveys completed and the response rate. This method was continued in 2006.

In early FY07, DMHDD will pilot the Tennessee Outcomes Measurement System (TOMS) - a consumer outcomes survey that will provide additional consumer and family feedback for domains of Quality of Life, Functioning, Symptoms and Substance Use, as well as information regarding living situation, employment and interface with the criminal justice system. The TOMS will eventually provide data on all persons receiving publicly funded behavioral health services through the twenty-two CMHAs providing contracted services in the state. A computerized survey system, TOMS will include an annual survey of selected questions developed through the DIG workgroup activities.

Goal 1.4: To increase availability of behavioral health interventions having consistent, scientific evidence showing improved consumer outcomes.

Name of Performance Indicator: EBPs – Number Provided
Criterion: 1 – Adult URS Developmental Tables 16-17
NOM ☑Yes ☐No Related to Transformation ☑Yes ☐No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	4	6	5	7	
Numerator					
Denominator					

Target: To provide all SAMHSA-recommended EBP services.
Population: Adults assessed as SMI.
Indicator: Number of SAMHSA-defined evidenced based practices being provided in Tennessee.
Source: DMHDD, CMHA Survey, BHOs
Issues: States may be providing other services qualified to be evidenced based practices that are not included in the URS table listing.
Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Action Plan:
Current URS Developmental Tables 16-17 list the following Evidenced Based Practices for adults:

1. Supported Housing
2. Supported Employment
3. Assertive Community Treatment
4. Family Psychoeducation
5. Integrated Treatment
6. Illness Management and Recovery
7. Medication Management

Tennessee has provided approved models of supported housing and supported employment for many years. Assertive community treatment and medication management is tracked by the BHO.

DMHDD encourages and contracts for the development of integrated treatment programs for individuals with co-occurring disorders (COD) of mental illness and substance abuse, but there is no reporting mechanism for this service. Routine data reported does not capture this and other EBPs.

As part of the DIG activities, the DIG workgroup discussed strategies to access EBP information. An agency survey was developed that listed each EBP for adults and children and youth.

Technical assistance will be sought to investigate other reporting methods. Currently, no other method appears to be a viable alternative to a provider survey. Upon receipt of survey results in 2005, all six listed EBPs were being offered by a number of providers across the state.

DMHDD piloted TN-MAP, the Tennessee Medications Algorithm Project at one RMHI with plans to implement at all five state psychiatric facilities.

Tennessee is one of four participants in the University of Pennsylvania's five-year work plan and research activities to promote recovery and community integration for persons diagnosed with mental illness. We have partnered with them to host and facilitate train the trainer sessions in Memphis on illness management and recovery and supported employment. The plan is to train fifteen persons at the Memphis training who will then train other provider staff in the city to fully implement these two evidenced-based practices. The University will be evaluating the effectiveness of these efforts over the next two years.

Goal 1.5: To assure access to behavioral health interventions for which there are consistent, scientific evidence showing that they improve consumer outcomes.

Name of Performance Indicator: **EBPs – Number Served**
Criterion: 1 – Adult **URS Developmental Tables 16-17**
NOM ☑Yes ☐No **Related to Transformation ☑Yes ☐No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
S Employment	N/A	464			
S Housing	N/A	570			
PACT	N/A	388			
Family Psy Edu	N/A	3,775			
Integrated Tx	N/A	8,218			
Illness Mgmt	N/A	16,300			
Med Mgmt	N/A	N/A			
TOTAL	**① 3,963**	**② 29,715**	**N/A**	**+500**	

① Includes only assertive community treatment and estimated counts of other known EBPs.
② Includes information reported on provider survey – med management not included.

Target: To increase by 500 the number of consumers receiving an Evidenced Based Practice (EBP).
Population: Adults assessed as SMI receiving publicly-funded behavioral health services during FY07.
Indicator: Number of SAMHSA-defined evidenced based practices being provided in Tennessee.
Source: DMHDD, CMHA Survey, BHOs
Issues: States may be providing other services qualified to be evidenced based practices that are not included in the URS table listing.
Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Action Plan:
DMHDD supports and promotes the development and implementation of evidenced based practices throughout the behavioral health system. Supported employment services are mandatory in the current BHO contracts. Illness Management and Recovery will be included in the new contract for Middle Tennessee. DMHDD's Three Year Plan includes strategies to improve best practices and provide training on specific EBPs (referenced on page 33).

Goal 1.6: To maximize the ability to remain in a community setting by providing coordinated service delivery in the most appropriate, least restrictive environment available.

Name of Performance Indicator: I/P Psychiatric Admission Rate
Criterion: 1 – Adult URS Developmental Tables 2A and 3B
NOM ☐Yes ☑No (State) Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	16.63%	15.74%	16.00%	16.00%	
Numerator	21,993	22,008			
Denominator	132,210	139,809			

Target: To maintain admissions to psychiatric acute care facilities at 16% or less.
Population: Adults enrolled in the TennCare Program.
Indicator: Percentage of adults receiving TennCare services who are admitted to acute inpatient care.
Measure: % Numerator: Unduplicated # of adults admitted to inpatient psychiatric acute care.
Denominator: Unduplicated # of adults receiving a TennCare Partners service.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: An acute care admission is defined as one that results in a hospital stay of less than thirty (30) days.
Significance: Monitoring inpatient utilization is one measure of the impact of TennCare benefit reductions.

Action Plan:
Alternatives to inpatient treatment have increased with the number of crisis service contacts, use of respite beds, and availability of 24/7 outpatient triage centers and stabilization services. Tennessee mandates a pre-screening evaluation admissions to RMHIs and BHOs require inpatient admission review. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis. Inpatient utilization is monitored by the BHOs, DMHDD and the Council Roundtable Committee.

Given the benefit limits imposed for most TennCare enrollees on August 1, 2005, monitoring of inpatient utilization is increasingly important to measure the impact of TennCare reform on those adults continuing to receive services through the managed care system. Tennessee has the capacity within its managed care program to report admissions to state and private hospitals. Overall inpatient utilization has generally increased since the implementation of managed care.

The FY05 data indicates a slight decrease in the hospitalization rate, but this largely reflects the months prior to TennCare reform. Perhaps surprisingly, projected FY06 data shows a significant decrease in inpatient utilization for TennCare enrollees. Given that the disenrollment process continues, a maximum of 16% target will be retained at this time.

Goal 1.7: To provide core psychiatric services and supports adequate to assist individuals to remain in the most appropriate, least restrictive environment available.

Name of Performance Indicator: **MHSN Inpatient Admissions**
Criterion: 1 – Adult **URS Table – N/A**
NOM ☐Yes ☑No (State) **Related to Transformation ☐Yes ☑No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	N/A	N/A	Baseline	16%	
Numerator					
Denominator			N/A		

Target: To limit psychiatric admissions to 16% or less.
Population: TennCare disenrolled adults with SMI registered for MHSN services.
Indicator: Percentage of disenrolled adults who are admitted to inpatient care.
Measure: % Numerator: Unduplicated # of adults admitted to state psychiatric hospital acute care during FY07.
Denominator: Unduplicated # of safety net eligible adults.

Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: Without health care benefits, state hospitalization is the only option available for inpatient services. Admission rate target is equal to that for TennCare recipients with full benefits (Goal 1.6)
Significance: Monitoring of outcomes of vulnerable individuals losing health care benefits is important to measure consumer needs and resources needed within the public mental health system.

Action Plan:
Approximately 26,000 adults scheduled to be disenrolled from TennCare are currently qualified to receive MHSN services by virtue of being assessed as SMI. DMHDD has been monitoring registration of these individuals with participating CMHAs and services received, including hospitalization.

Performance indicator results can give us a clearer picture of the impact of TennCare reform on this population, the adequacy of safety net services, and data important to advocating for additional state resources where necessary.

Please note that this indicator is not applicable to previous years. The goal for FY06 was to establish a baseline that can be used to determine whether MHSN services are sufficient to maintain adults with SMI, who lost health care coverage, in their communities. The overall goal is to document that individuals receiving MHSN services have inpatient utilization rates no higher than prior to disenrollment from TennCare.

Criterion 2: Mental Health System Data Epidemiology

Goal 2.1 **To maintain access to publicly funded behavioral health care for adults.**

Name of Performance Indicator: **Increased Access to Services**
Criterion: 2 – Adult **URS Basic Table 2A and Other Data**
NOM ☑Yes ☐No (State) **Related to Transformation ☐Yes ☑No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	132,210	139,809	104,000	105,000	

Target: To reinstate service access to an additional 1,000 adults.
Population: Adults receiving publicly funded behavioral health services.
Indicator: Unduplicated number of adults served by age, gender and race/ethnicity.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
DMHDD, Division of Recovery Services and Planning, MHSN
Issues: Publicly funded services include clinical services provided under the TennCare Partners Program and the Mental Health Safety Net Services Program. As of August 2005, DMHDD is contracting directly for clinical services to TennCare disenrolled adults.
Significance: Approximately 200,000 adults were scheduled for disenrollment from the TennCare. This will result in smaller numbers of persons eligible for services under that program. A proportion of those with SMI will be served through the MHSN program.

Action Plan:
At various times in the past three years, up to 1.6 million individuals were eligible to receive a behavioral health service under the TennCare Partners Program. In FY03 to FY05, the number of adults served increased by approximately 6,000 persons annually.

As part of TennCare reform, disenrollment of the waiver population began in August 2005. As of May 31, 2006, TennCare enrollment was at just below 1.2 million, comparable to enrollment of ten years ago. The percent of total TennCare enrollees age 18 and over has dropped from 59% in May 2003 to 50% in May 2006.

Preliminary data for FY06 show that, as expected, the number of adults served through the TennCare Partner's program has decreased following waiver population disenrollment, showing an overall decrease of nearly 26% in the number of adults served.

Non-priority population adults comprise approximately 90% of the total TennCare population and received 35% of behavioral health services within the TennCare population in FY05. For those retaining TennCare enrollment or becoming Medicaid eligible, community education about TennCare eligibility and access to services is provided regularly through Bureau of TennCare, BHO, DMHDD and community advocacy group efforts.

Disenrollees are expected to be given first priority for health care coverage under the Cover Tennessee initiative.

Goal 2.2 To ensure access to necessary mental health services for adults with SMI within the public mental health system.

Name of Performance Indicator: **SMI Priority Population Access**
Criterion: 2 – Adult **URS Basic Table 14A and Other Data**
NOM ☐Yes ☑No (State) **Related to Transformation ☐Yes ☑No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	81,877	91,254	82,000	83,000	

Target: To provide services to a minimum of 1,000 additional adults with SMI.
Population: Adults assessed as SMI and receiving any publicly funded behavioral health services.
Indicator: Number of adults with SMI served by age, gender and race/ethnicity.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
DMHDD, Division of Recovery Services and Planning, MHSN
Issues: Publicly funded services include clinical services provided under the TennCare Partners Program and the Mental Health Safety Net Services Program. As of August 2005, DMHDD is contracting directly for clinical services to TennCare disenrolled adults.
Significance: Approximately 200,000 adults were scheduled for disenrollment from the TennCare. This will result in smaller numbers of persons eligible for services under that program. A proportion of those with SMI will be served through the MHSN program.

Action Plan:
It is noted that the population for this performance indicator has been expanded to include adults with SMI receiving any publicly funded behavioral health service. The majority of adults with SMI receive treatment services as enrollees in TennCare. Priority population adults comprise approximately 10% of the total TennCare population, but accounted for 65% of behavioral health service recipients within TennCare in FY05, a 3% increase over FY04.

Service access for non-TennCare adults with SMI in need of treatment is expedited under a “state only” category pending Medicaid eligibility determination and a “judicial” category for court-ordered services. How long these service eligibility categories will be maintained is in question due to budgetary constraints. Since FY06, TennCare disenrolled adults with SMI have been eligible to receive services through the MHSN.

Preliminary FY06 service data for adults indicates a decrease in the number of adults served. It is anticipated that the number of adults with SMI served through TennCare Partners will further decrease in FY07. Nearly 12,000 adults with SMI received services through the MHSN between August 2005 and July 2006 and that number is expected to increase in FY07.

Determining factors for service access include the status of state only and judicial category funding, the success of safety net registration efforts and the continued ability of community providers to financially support free care or sliding scale fees for those adults with SMI requiring services.

Goal 2.3 To ensure access to public mental health safety net services for priority population adults losing health care benefits.

Name of Performance Indicator: Safety Net Registration
Criterion: 2 – Adult URS Table – N/A
NOM ☐Yes ☑No (State) Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Actual*	*FY07 Target*	*FY07 Attained*
Performance Indicator	N/A	N/A	57%	65%	
Numerator			12,470		
Denominator			21,819		

Target: To maximize CMHA registration of disenrolled adults for assistance.
Population: Adults with SMI eligible for safety net services.
Indicator: Percentage of disenrolled adults registered for safety net services.
Measure: % Numerator: Number of safety net eligible adults registered with a CMHA for service assistance.
Denominator: Total number of disenrolled adults eligible for safety net services.
Source: DMHDD, Division of Recovery Services and Planning, Office of Mental Health Safety Net Services
Issues: Monitoring assures accountability of safety net dollars and provides an estimate of resource needs.
Significance: The impact of TennCare reform will not be known immediately. It is important to maintain needed medications and basic services for those most in need.

Action Plan:
The number of adult disenrollees eligible for MHSN services was initially limited to those with a current (within twelve months) assessment of CRG 1, 2, or 3 posted in the TennCare database as of June 6, 2005, approximately 21,000 adults. That eligibility group was broadened to any adult disenrollee being assessed as SMI.

Adults who were current clients when disenrolled from TennCare received outreach through letters and personal contact by their community provider agency. NAMI-TN has been contracted to provide support, through community education and outreach activities regarding utilization of MHSN services, pharmacy options, pharmacy assistance and Medicare Part D, to any person disenrolled from the TennCare demonstration project by virtue of the approved TennCare waiver amendment or a family member, friend, or other social supporter of such a person.

The actual effective date of benefits loss varies based on the category of eligibility and appeal status. Lists of persons and their effective dates of disenrollment are sent to DMHDD weekly and to the twenty CMHAs contracted to provide MHSN services to expedite outreach efforts in their service areas.

As of June 30, 2006, 21,819 adults with an assessment of SMI had been officially disenrolled from TennCare, and 57% of them had registered with a participating CMHA for MHSN services.

Criterion 3: Not Applicable to Adult Plan

Criterion 4: Targeted Services to Rural and Homeless Populations

Goal 4.1: **To impact the cycle of homelessness for adults with SMI through outreach, assistance and referral.**

Name of Performance Indicator: **Homeless Adult Services**
Criterion: 4 – Adult **URS Basic Table 15 and Other Data**
NOM ☐Yes ☑No (State) **Related to Transformation ☐Yes ☑No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	N/A	N/A	N/A	Baseline	
Numerator					
Denominator					

Target: To decrease the number of PATH recipients returning to homelessness after being transitioned to integrated community mental health services.
Population: Adults with SMI who are homeless.
Indicator: Baseline percent of served individuals reported as returning to homelessness.
Measure: % Numerator: Number of homeless adults returning to homelessness after case management services.
Denominator: Total number of adults receiving case management services during FY07.
Source: Annual Report by PATH Agencies to DMHDD
Issues: Note that FY07 goal has changed from service goal from previous years to outcome goal.
Significance: Homeless advocates have stressed the housing first/employment first philosophy for ending chronic homelessness.

Action Plan:
Of the 4,786 adult service recipients responding to the consumer survey in FY05, 2% chose “Homeless” or “Shelter” options to describe their living situation. Another 10% chose “Other”, which might indicate other homeless situations such as living in a car, outdoors, etc. With the establishment of the TOMS, we will be able to get a more accurate picture of how many of our current service recipients are homeless.

Tennessee is dependent on federal dollars for outreach services to the adult homeless population. During FY06, DMHDD and federal funding supported ten PATH projects. Each program location has a projected number of outreach contacts and case management enrollment targets. Outreach and case management services are available to those homeless adults with mental illness who are not in treatment to ensure that persons eligible for services are aware of and have access to community resources.

Regional housing and employment facilitation staff work closely with PATH program coordinators to provide services to individuals receiving services through homeless outreach.

Criterion 5: Management Systems

Goal 5.1: To provide support and recovery-oriented services for adults with SMI.

Name of Performance Indicator: Recovery Oriented Service Focus
Criterion: 5 – Adult URS Table – N/A
NOM ☐Yes ☑No (State) Related to Transformation ☑Yes ☐No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	57%	55%	55%	50%	
Numerator	4,532,880	4,227,300	4,201,300		
Denominator	7,900,900	7,730,700	7,647,500		

Target: To expend a minimum of 50% of Block Grant funding for recovery-oriented services for adults with SMI.
Population: Priority population Adults
Indicator: Percent of block grant funds allocated for recovery-oriented services.
Measure: % Numerator: Amount of Block Grant dollars spent on recovery-oriented services
Denominator: Total amount of Block Grant funding minus administrative costs
Source: DMHDD Budget
Issues: Allocations based on continued ability to expend Block Grant funding for non-treatment services.
Significance: In light of loss and reduction of health care benefits, recovery-focused activities promote peer support, illness management and self-directed service options.

Action Plan:
Non-clinical services, especially recovery and support services are considered important for maintaining wellness, promoting empowerment, improving community reintegration and contributing to improvement in an individual's quality of life.

Since 1996, DMHDD has utilized Block Grant dollars to pilot, promote, maintain and enhance a variety of service initiatives and alternatives to assist consumers to live, work, learn, and participate fully in their communities despite their illness.

Proposed allocations include projects in consumer support and educational activities, including BRIDGES, and consumer run Peer Support Centers. Each of these service projects features mentoring, educational courses and peer counseling activities to aid each consumer to recover to the best of his or her ability.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

b) CHILDREN'S MENTAL HEALTH SYSTEM

Criterion 1: Comprehensive Community-Based Mental Health Service System

Approximately 50,408 children and youth below the age of eighteen received behavioral health services through the TCPP in FY05, a 4.5% increase over FY04. (URS Table 2A) In FY05, nearly 91% of returned Youth Services for Families surveys reported positively about access, an increase from 83% in FY04. (URS Table 11a)

An additional 255,868 children and youth and 18,059 teachers, parents and other adults were served through DMHDD community contracts; nearly 200,000 of them through Block Grant funded services. The medical and behavioral benefits offered under TennCare and TennCare Partners, combined with the early intervention, prevention, education and support services provided with state and federal grant dollars, serve to provide a comprehensive array of community services.

In FY05, there were slight increases in numbers served in most race and ethnicity categories. There was a very slight decrease in the number of African Americans served as compared to FY04. Most are generally comparable with 2000 census data estimates, although regional differences are not reflected in the aggregate data. The most notable increases were in the number of children served who identified as Hispanic and Asian.

Age breakout of service recipients remains generally the same: 53% between the ages of 4 and 12, 45% between the ages of 13 and 17, and a slight decrease in services to children under age 4. Of the total number served (all ages), 4% were youth age 18-20. Sixty percent (60%) of those served were male.

There were very slight increases (<1%) in the inpatient rate for children and youth below the age of 18 served in psychiatric hospitals between FY04 and FY05 in both state and other psychiatric hospitals. There was a similar slight increase in the residential treatment rate. (URS Table 3) The interventions of a statewide specialized crisis services program for children is thought to be having the desired effect with its focus on hospital diversion through in-home intervention and referral to community resources.

Criterion 2: Mental Health System Data Epidemiology

Using the highest range number for Tennessee in the prevalence tables provided by CMHS for URS Table 1, there are 92,330 children and youth between the ages of 9 and 17 estimated to have SED. Approximately 58,719 persons under age 18 and assessed as SED were enrolled in the TennCare Program for some time during FY05. This penetration measure had climbed steadily since 1998, but decreased by some 10% between FY04 and FY05 and appears to be continuing to decrease slightly for FY06.

During the six-month period of November 2005 through April 2006, the number of priority child TennCare enrollees remained generally steady in most of the seven mental health planning regions with a slight decrease in Region VI and a slight increase in Region I. However, children and youth with SED comprise nearly 4% of current enrollment, and that percentage has remained generally stable throughout TennCare's history.

Some 57% of the persons under age 18 receiving services in FY05 were children and youth assessed as SED, an increase from 52% in FY04. (URS Tables 2A and 14A)

Criterion 3: Children's Services

Given the various departments involved in services to children, e.g., DCS for children in custody, Education for schools, Health for TennCare and substance abuse services and Mental Health for behavioral health care, it is necessary for careful attention to integration of effort. By Executive Order, the Governor's Children's Cabinet was established in 2003 to coordinate and streamline services to children. The Commissioner of each child-serving department, child advocate organizations and citizens with a strong commitment to and understanding of the challenges and issues affecting Tennessee's children serve as members. Areas of targeted impact for FY06 were infant mortality, truancy and student pregnancy.

In 2004, the Governor's Office of Child Care Coordination was established to ensure that the delivery of services to children is effective, efficient and coordinated. This group reviews problematic cases involving multiple agency providers and identifies gaps in service coordination that impede success. Findings may then be forwarded to the Children's Cabinet for Commissioner review and policy revision as needed.

TennCare policy is targeted to broaden eligibility to all children of low-income families without access to insurance coverage. The CoverKids portion of the Cover Tennessee program aims to assure health care coverage to every child in the state.

In the arena of mental health, Tennessee is able to utilize state and Block Grant dollars to provide a variety of early identification, intervention, prevention, and family support services not always seen in other states.

Criterion 4: Targeted Services to Rural and Homeless Populations

The state is currently able to report living situation, including homeless status, only for those adults completing the FY05 consumer survey. (URS Table 15) Approximately 2% of 4,370 responders indicated "Homeless/Shelter" for living situation; an additional 10% marked "Other", which might include non-shelter homelessness. Estimates of the number of homeless families with children ranges from 4,000 to 4,500. School system data shows a gradual increase each year of homeless children attending school.

Six outreach programs for homeless families with at-risk children refer homeless families to appropriate services through outreach and provide case management services to families and children. This program is one of the few of its kind for children who are living in homeless families and is making a measurable impact on this population. Approximately 19% of children served in FY05 were assessed as SED.

Approximately 25% of children with SED enrolled in TennCare reside in a rural county. This percentage decreased from 44% following the 2000 US Census, which resulted in a drop from 77 to 59 in the number of Tennessee counties designated as rural.

Criterion 5: Management Systems

Specific to services for children, there is continuing need for increased clinical staff with specialization in this area, especially outside of the metropolitan areas. The BHO provided funding to expand clinical staff for children's services at various agency locations across the state. Telemedicine is also assisting in this effort, providing initial assessments and specialist consultations.

Training for first responders and other mental health staff assisting in critical incident and disaster response include specific courses in trauma interventions with children and school-based intervention planning and response.

Strengths and Weaknesses of the System

Strengths of the current system of care for children and youth include: targeted prevention and early intervention activities for pre-school and school-age children; expansion of systems of care; planned respite services; outreach to homeless families with children; anti-stigma educational efforts for students, teachers and parents; and service programs for targeted special populations.

DMHDD supports a school-based suicide awareness and prevention program for middle and high school students and has begun a federal grant program to reduce suicides and suicide attempts in high-risk youth ages 10-24. The project targets youth in state custody or at risk of custody, in juvenile justice, alternative schools or special education programs, youth with school disciplinary and/or truancy problems and gay, lesbian, and bisexual youth.

In addition, it is noted that TennCare coverage to children and youth under age 18 was not included in disenrollment and benefit reductions; assuring health care coverage for children continues to be a priority.

Challenges continue in developing a broad availability of in-home service options and transitional services for youth age 16-21, although there has been movement toward initiatives in these areas.

Unmet Service Needs

Service needs are identified through an annual needs assessment process with input from all regional and state councils and DMHDD staff divisions. They are then reviewed and prioritized as recommendations for inclusion into the Three Year Plan by the Planning Committee of the MHDD Planning and Policy Council. This process allows for a broad grassroots forum to advise the Department on the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families and provides citizen participation in the development of the DMHDD annual budget improvement request.

For FY07, DMHDD Council priorities for children and youth services include:1) continuation of Peer Power, an in-school violence prevention program designed for 4th and 5th grade youth, 2) expansion of BASIC, a K-3 early identification and intervention program, and 3) expansion of the school-based mental health liaison program.

Plans to Address Unmet Service Needs

Title 33 of the Tennessee Code Annotated, the mental health and developmental disability law, requires the DMHDD to develop a Three Year Plan based on the DMHDD Planning and Policy Council recommendations. The plan must be updated at least annually, based on an assessment of the public need for mental health and developmental disability services and supports. The Department's improvement budget request is tied to the annual update of the plan.

The FY07 budget request included the following service initiatives for children and youth:

- Funding to provide three part-time positions for continued post-grant operation of the Peer Power Resilience Anti-Violence Program
- Funding to provide eight additional school-based Mental Health Liaisons to provide mental health education and support for classroom teachers and other school personnel.
- Improvement funding to provide nine coordinator positions to expand the Regional Intervention Program (RIP), a successful program for the early treatment of children with behavior disorders.

Of these requests, only the Peer Power program was funded.

New Freedom Commission goals form the framework of the Three Year Plan. The Department modified the goals to include persons with developmental disabilities to develop objectives and strategies that will assist the Department in planning integrated services and supports essential to persons with mental illness, serious emotional disturbance or developmental disabilities. Strategies for FY07 in the FY2007-2009 Three Year Plan related to unmet service needs identified by staff and stakeholders for children and youth include:

Strategy 3.2.8: To collaborate with other state agencies to assess and resolve issues in the delivery of services to children and youth with mental illness and serious emotional disturbance.

Strategy 3.2.10: To collaborate and partner with other state and local agencies to assess and evaluate procedures needed to enhance the transition of adolescents to adult mental health services.

Strategy 3.2.31: To seek funding options to expand school-based mental health services.

Strategy 4.1.3: To provide prevention and early intervention services for at-risk children including, but not limited to, suicide prevention.

Strategy 4.1.5: To expand BASIC, a prevention and early intervention program for K-3 elementary school children.

The current Three Year Plan is available for review on the DMHDD website at http://www.state.tn.us/mental/overview/html – link on left banner.

Summary of Significant Achievements Reflecting Progress Towards the Development of a Comprehensive Community-based Mental Health System of Care

Services to children and youth TennCare enrollees increased; 2,171 more persons under age 18 received services in FY05 than in FY04. Of the total number served, the proportion that were children and youth with SED increased from 52.5% in FY04 to 57.1% in FY05.

Other achievements in FY06 that reflect development of a more comprehensive system of care for children and youth include:

- Attaining a three-year federal grant award to provide support services, community education and direct services to expand access and treatment for methamphetamine addiction for individuals and their families in rural counties in Middle Tennessee.
- Attaining a three-year federal grant, Tennessee Lives Count (TLC), to reach high-risk youth, ages 10-24, by providing training in lethality assessment, needs assessment and stigma reduction activities. Under this grant, an enhanced university curricula for suicide prevention will be developed.
- Attaining a six-year federal grant to establish a system of care network in Maury County in the Middle Tennessee area.
- Post-grant transitioning of the Nashville Connection system of care services for children and youth in Nashville/Davidson County to a DCS-contracted statewide system of care for children in state custody.

Brief Description of the Public Mental Health System Envisioned for the Future

A major goal for children's services is expanding the system of care approach throughout the state. System of care integration promotes coordinated service planning that leads to decreased out of home placement, increased family stability, improved clinical outcomes, and improved school attendance and performance. The continuation of the systems of care delivery model for children and youth in state custody is a significant accomplishment.

The advent of CoverKids, a part of the Cover Tennessee initiative, will provide health insurance coverage, including behavioral health benefits, to uninsured children in the state. Eligibility is capped at 250% of the federal poverty level, but those with higher incomes may be able to buy-in to the program.

Efforts of Senate Joint Resolution 799's mandate to design a comprehensive, coordinated, family-centered and culturally responsive system for behavioral health care is expected to more specifically define the future public mental health system for services to children and youth.

b) CHILDREN'S PLAN

Establishment of System of Care (Also see Adult Plan)

In addition to statute cited under a) Adult Plan, Establishment of System of Care, Title 33, Chapter 2, 105 states:

The department shall establish areas for planning and resource allocation. The department shall define geographically dispersed and accessible points of access to service systems and designate providers or mechanisms to provide information and referral for services and supports and for eligibility decisions.

Capitation payments for managed care services and DMHDD grant funding is allocated to community mental health providers to provide services to children and youth within their respective geographic service areas. However, CMHAs may additionally provide services through satellite offices in other regions and persons with health care coverage may seek services from providers of their choice.

1) Current Activities – Children and Youth Plan – Available Services

i. Criterion 1 A Comprehensive Community-Based System of Care

Mental Health Services: Access to any TennCare Partners service is accomplished by meeting the medically necessary criteria for that service or being referred through EPSDT screening services. Benefits include:

- Inpatient Psychiatric Treatment
- Outpatient Mental Health Services
- Inpatient/Residential and Outpatient Substance Abuse Treatment Services
- (10 days detox and $30,000 lifetime limit for non-priority population enrollees)
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Specialized Outpatient and Symptom management
- Specialized Crisis Services and Respite

In addition to the TennCare medical and behavioral health benefit package, the following services are available within the comprehensive array of community services:

Health – Public Health
Tennessee has made a commitment to promoting good health in children from birth until age 21. TENNderCARE is a full program of check ups and health care services for children who have TennCare. These services assure that babies, children, teens and young adults receive the health care they need. (www.state.tn.us/tenncare/child.html) All contracted mental health services promote and provide referral for these early and periodic screening services. Primary care practitioners and pediatricians are educated about physical and emotional developmental benchmarks.

Vaccines and immunization services for children are available through ninety-five county and metropolitan health clinics in Tennessee and at over 1,500 physicians' offices in Tennessee. Free vaccines may be given to children who are enrolled in TennCare, are without health insurance, or are of American Indian or Alaskan Native ethnicity. Children who are insured, but whose health insurance does not cover immunizations, can also get free vaccinations at federally qualified health centers, rural health centers, or local health departments.

Tennessee has a comprehensive genetics program that provides access to newborn screening for genetic/metabolic disorders and newborn hearing screening for early detection of hearing loss.

Rehabilitation Services:
There are no specific rehabilitation services for children and youth. However, rehabilitative activities occur within a number of day treatment, respite, educational, residential, and transitional programs. Transitional age youth are encouraged to participate in psychosocial rehabilitation center and peer support center activities.

Employment Services: The Department of Education requires transition plans to be included in the Individual Education Plans of all children in special education who are fourteen years or older, some of whom are assessed as SED. This includes the assessment of vocational alternatives. The Division of Rehabilitation Services provides transition-from-school-to-work case managers within the schools and designates Rehabilitation Counselors to work with a school.

Residential Treatment Services: The DCS provides community-based, twenty-four hour residential treatment for a specialized sub-population of children and youth with SED. DCS also supports regular foster care and therapeutic foster care programs.

Housing Services: DMHDD supports the Creating Homes Initiative that leverages funding and promotes collaboration for development of a continuum of housing options for persons with disabilities, including families with children. Independent Living Assistance provides priority population consumers with families initial and supplemental utility and rent deposits to enable individuals to maintain housing of their choice. A strategy to develop supported housing options for youth aging out of state custody is currently in the discussion stage.

Educational Services: Day treatment services are funded for children and youth with SED through the TCPP. DMHDD has recommended school-based day treatment to be the preferred model for delivering this service. Non-school-based day treatment programs, which provide education as a component of the program, must qualify as approved schools per DOE policies and procedures.

Tennessee designates lottery revenues to education: from pre-school to college scholarships. Pre-kindergarten programs, with first priority to at-risk four-year-olds, provide opportunities to develop school readiness skills. The Lottery Education After-school Program (LEAP) has provided nearly $6.7 million for eighty-eight new after-school programs for at-risk students across the state.

Medical and Dental Services: Primary Care Physician and Specialist Medical Services are available under TennCare. EPSDT assessments are expected for all Medicaid enrolled children under twenty-one. Medical and dental services are provided as medically necessary for children and youth eligible for TennCare.

Substance Abuse Services: Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of both the BHOs and the DOH, BADAS. Initiatives for children include Residential and Day Treatment programs for adolescents, intensive focus prevention programs, the Tennessee Teen Institute and the Faith Initiative, a program that promotes local church involvement in outreach, training, and education services which target pre-adolescent children living in single parent households in inner-city housing developments.

Case Management Services: Mental health case managers serve as the agent for linking, facilitating, and monitoring the receipt of direct services and supports. Mental Health Case Management is a benefit of the TennCare Partners Program. Children and youth are assessed for level one and level two case management services regardless of priority population status. The assessment process provides for measurements of intensity and duration needed and proposed objectives to be met in the service plan. There are documented policies regarding all level one and level two case management caseload capacities and expected consumer outcomes.

Services for Co-occurring Disorders (COD): Children with co-occurring disorders have access to the range of services offered by TennCare and the BADAS. The TCPP has pursued the development of intensive outpatient services for adolescents with co-occurring disorders in targeted deficit areas. There are four specialized programs to serve youth with Substance Abuse and COD serving thirty-one counties.

Services for Special Populations: DMHDD supports the following service initiatives for children and youth with special needs:

- Services for Children and Youth with Dual Diagnosis of SED and Mental Retardation or Developmental Disability: Three projects provide therapeutic foster care, case management, and intensive in-home treatment and support services for dually diagnosed children and youth.

- Services for Children and Youth in the Juvenile Justice System: Forensic evaluation and treatment services are provided for youth under Juvenile Court Order. Juvenile sex offender assessment and treatment programs are funded in six locations across Tennessee.

- Services for Children of Parents with SMI: This is a program to provide education and support for children and youth who have a parent diagnosed with a mental illness through a school-based outreach curriculum, Mental Health 101.

Support Services: DMHDD funding supports the following services:

- Tennessee Voices for Children (TVC), the Tennessee affiliate of the Federation of Families for Children's Mental Health, manages a family support group network across the state for families of children with SED, with family groups in each of the three grand regions of the state.

TVC provides technical assistance and consultation for the development of these groups, distributes printed materials, refers families to services, and performs parent advocacy and training activities through family outreach specialists.

- Planned Respite Services: A model program that provides respite services to families of children identified with SED or dually diagnosed with SED and mental retardation ages two to fifteen.

- Parent/Professional Support Groups: These support groups are facilitated by both a parent of a child with SED and a professional. The member families determine the agenda and hire their own professional co-facilitator. Respite consultants provide short-term respite and work with the family to identify long-range respite resources.

Activities to Reduce Hospitalization

- Pre-screening: A pre-screening evaluation is mandatory for eligibility for emergency involuntary admission to state mental health institutes. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis. Pre-screeners assessing children must meet additional experience criteria related to working with children.

- Mobile Crisis Response Services: A specialized crisis response service is targeted to children and youth for individual and family intervention. Crisis response services are available 24/7 in every county in Tennessee. Approximately 66% of face-to-face contacts result in diversion from an inpatient setting.

All services under Criterion 1 have been implemented. The focus on building systems of care statewide is expected to increase provider collaboration and positive consumer and family outcomes.

Transformation Activities: (Goal numbers correspond to goals and recommendations in a transformed mental health system as recommended by the President's New Freedom Commission on Mental Health report.)

Goal 1.1: Advance a campaign to reduce the stigma of seeking care and a strategy for suicide prevention.

Contracted through the Mental Health Association, DMHDD supports a statewide education and information program about mental health and mental illness, children and youth with SED, their needs and the needs of their families. *Erasing the Stigma* and *Kids on the Block* presentations are made to forums of youth and adults with the goal of promoting knowledge about mental health and reducing stigma. Events, project goals and presentations are developed in collaboration with major children's advocacy groups. Nearly 5,000 adults and 50,000 children attend these presentations annually.

Tennessee Lives Count (TLC), a three-year federal grant to reach high-risk youth ages 10-24, provides gatekeeper training in lethality assessment, needs assessment and stigma reduction activities. TLC targets youth in or at risk of state custody, in juvenile justice, alternative schools or special education programs, youth with school disciplinary and/or truancy problems and gay, lesbian, and bisexual youth.

DMHDD supports the Jason Foundation youth suicide prevention curriculum in more than 800 middle and high schools across the state as well as churches and other community organizations that work with children.

Goal 5.2: Advance evidenced-based practices using dissemination and demonstration projects.
The system of care model is identified as an emerging best practice in *Achieving the Promise* and is the least fragmented and most collaborative model of care for children and youth with SED and their families.

The Nashville Connection, a five-year federal system of care grant that ends August 31, 2006, established a state infrastructure and on-going evaluation for a system of care for services to children and youth in Nashville/Davidson County. This grant led the way in coordinating resources, providing support to families, involving youth in treatment options and strategizing for replication and sustainability of the model across the state. This system of care model will continue under a contract between DCS and TVC. While funding constraints will limit service delivery to children in state custody, the program will be available statewide.

The Early Childhood Network is a collaborative effort among local child serving entities in Maury and Rutherford Counties to identify and address the mental health needs of children from preschool through third grade using prevention and early intervention strategies. This effort is intended to provide a seamless and comprehensive system to identify and serve, at an early age, children in need of mental health services by networking all local agencies that work with these children.

The Mule Town Family Network, a six-year federal system of care grant awarded in September 2005, builds upon this coordinated effort of state, county, local agencies, individuals, service recipients and their family members to provide wraparound services for children and youth with SED in Maury County.

ii. Criterion 2 Mental Health System Data Epidemiology

Tennessee utilizes the federal definition of SED: Children and adolescents from birth up to age eighteen years who currently have, or at any time during the past year have had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Children and youth are classified by use of a Targeted Population Group (TPG) form. Assessments are done by DMHDD approved raters from authorized CMHAs and RMHIs. The degree of functional impairment is assessed with the Global Assessment of Functioning (GAF). Those meeting the federal definition with a GAF of 50 or below are considered SED and classified as TPG 2.

Estimates of the annual prevalence of SED in Tennessee from the CMHS 2004 census estimate for URS Table 1 for children and youth aged nine to seventeen ranges from 49,716 to 92,330. Due to a high percent of poverty and the fact that data reported will include all children and youth below the age of eighteen, the highest federal estimate, 92,330, will be utilized.

In FY06, approximately 57,633 children and youth under age 18 identified as SED were enrolled for some period of time in the public mental health managed care system, approximately 62% of the prevalence rate. Just less than half of that number maintain a current (within one year) assessment of SED. Of that number, 91% received a behavioral health service. Given the continuing decrease in the number of children and youth enrolled in the TennCare system, FY07 targets will be set to maintain services at that 90% level.

During FY07, DMHDD Block Grant and state funded services are estimated to provide services to over 220,000 children, families, caregivers, and others.

Further quantitative goals for FY07 are included in Section III, Number 2 of the Child Plan, Goals, Targets, and Action Plans beginning on page 68.

iii. Criterion 3 Children's Services

The system of mental health care for children and youth, including those with SED, consists of four service delivery entities: TennCare/TennCare Partners; DCS for children in or at risk of state custody; DMHDD-contracted services and state hospitals; and the DOH, Bureau of Alcohol and Drug Abuse Services.

- The Bureau of TennCare contracts with MCOs and DMHDD contracts with BHOs to deliver medically necessary physical care, mental health care, and substance abuse services, including EPSDT assessments for TennCare eligible children and youth to age twenty-one. A Memorandum of Understanding (MOU) between the Bureau of TennCare and DMHDD serves to further the integration of policy and program development for children and youth receiving services under the TCPP.

- DCS was created by joint effort of the General Assembly and the Governor's Office in July 1996 to fulfill the state's responsibilities for children committed to, or at risk of commitment to, the state's custody. These custodial duties were previously distributed across the Departments of Mental Health and Mental Retardation, Human Services, Youth Development, and Education. DCS provides for children who are placed in state custody, or are at risk of placement in state custody.

  DCS provides an array of services to the approximately 9,500 children and youth in legal and physical state custody. Many of these children enter custody due to neglect, abuse, abandonment, delinquency, or are awaiting adoption.

  Almost all custodial children and youth are enrolled in TennCare. The TCPP provides for medically necessary services with the exception of residential treatment services, which are the responsibility of DCS. Mental health case management services for children in state custody with SED can be accessed through the TCPP.

  DCS has specific policies and procedures in place to maintain youth in placements inside Tennessee whenever possible. Placements are tracked through the TCPP contract for both DMHDD and DCS youth. Such placements have been in the single digits for the past three years. Youth placed outside the state are generally in need of specialized services.

- DMHDD, through Block Grant funding and state appropriations, contracts with multiple agencies to deliver education, prevention, early intervention, respite, and outreach mental health services for children and youth with or at risk of SED.

  DMHDD manages children and youth inpatient psychiatric programs that provide acute and extended care in two of the state psychiatric hospitals and contracts for outpatient and inpatient mental health evaluations of children and youth ordered by juvenile courts.

- The Bureau of Alcohol and Drug Abuse Services provides for education, early intervention, and non-TennCare-covered substance abuse treatment services for children and youth through state funding and the Substance Abuse Block Grant.

Tennessee's integrated statewide system of services for children and youth with SED includes social, education, juvenile justice, substance abuse, and mental health.

The service integration is accomplished via multiple linkages and interactions between the four primary departments of state government that serve youth and their respective networks of provider agencies. The Departments of Health, Education, Children's Services and Mental Health and Developmental Disabilities each have complementary responsibilities for meeting the needs of children and youth.

- Social Services: DMHDD provides consultation to DHS staff on mental health treatment issues, community resources, and referral procedures to utilize in the training of case managers who will work with special needs families participating in Tennessee's welfare to work program, Families First.

- Educational Services: The DOE approves the special education annual plans of all schools operated by DMHDD and DCS. Staff from each department participates in common projects (e.g. Dropout prevention, Family Resource Centers). In addition, DMHDD has an extensive presence in school systems with the Jason Foundation curriculum and, particularly, in rural areas with Project BASIC. (See service descriptions in Criterion 5 on pages 66 and 67.)

- Juvenile Services: DMHDD contracts for court-ordered evaluations and mental health services for children and youth committed by the juvenile court. Both inpatient and outpatient evaluation services are provided. DMHDD Forensic Services staff monitor all evaluations and assist in accessing recommended treatment services as necessary.

  In order to assess the prevalence of mental health, substance abuse and developmental disabilities among youth in juvenile justice facilities, a survey was conducted of forty facilities across the state in late 2003. Based on needs identified in the survey, a Juvenile Justice Workgroup of the Criminal Justice Committee worked with various state and judicial entities to develop a screening process to be used at the earliest possible contact point with the juvenile justice system, so that behavioral health problems could be detected and treated early on.

  Twelve screening tools were reviewed and a report issued to the Tennessee Commission on Children and Youth (TCCY) in January 2006. A recommendation was made to use the GAIN-SS (Global Assessment of Individual Needs, Short Screen). A Request for Proposal (RFP) to conduct the screenings was issued by

TCCY with no responses. TCCY plans to reissue the RFP during 2007 before developing an alternate plan.

- Substance Abuse Services: The Bureau of Alcohol and Substance Abuse Services provides a number of prevention programs for children, including intensive focus groups, the Tennessee Teen Institute, and The Faith Initiative, targeting pre-adolescent children living in single parent households in inner-city housing developments.

  Bureau-funded treatment services are primarily targeted to persons with no other means of paying for treatment. Funding also targets special needs populations such as pregnant women, women with dependent children, adolescents, and persons of any age at risk for or infected with HIV.

- IDEA Services: PL 105-17, the Individuals with Disability Education Act is administered by the DOE. Services and activities developed under Tennessee's Part C process include: an 800 telephone number information and referral line, a directory of services available in each area of the state, child-find activities, community awareness activities, and contracted mental health case management services. All children included in Part C have an Individualized Family Service Plan and appropriate services provided. An Interagency Coordinating Council meets regularly to guide these activities and to develop and monitor the State's Plan for Part C. Disabilities that can be served under Part C include social and emotional delay.

  Special education and related services for children and youth with SED are specified in an Individualized Education Plan and provided by the local education agencies, the DCS contract provider or facility school for children in state custody, or schools operated by DMHDD for children and youth in RMHIs. An interagency agreement defines the fiscal responsibilities for special education related services between DOE and the Bureau of TennCare.

- Transitional Services: Coordinated service and life planning for youth transitioning into adulthood are necessary components of a comprehensive behavioral health system and must be tailored to the unique needs of this population. Many of the system barriers to continuity between youth and adulthood have been identified through efforts by advocates and providers. These efforts have culminated in the development of a statewide task force for transitional services development.

  Staff within the Division of Recovery Services and Planning are collaborating with DCS to obtain appropriate housing options for children aging out of state custody and preparing to live independently.

Transformation Activities: (Goal numbers correspond to goals and recommendations in a transformed mental health system as recommended by the President's New Freedom Commission on Mental Health report.)

Goal 2.2: Involve consumers and families fully in orienting the mental health system toward recovery.
Strategies for FY07 in the DMHDD Three Year Plan include:

- to develop and conduct a conference that will focus on recovery and resilience for service recipients and their families and a leadership conference for parents who have children with SED.

Goal 4.1: Promote the mental health of young children.
Strategies for FY07 in the DMHDD Three Year Plan include:
- to expand prevention, education, early intervention and support services for children and their families impacted by, or at risk of, mental illness or serious emotional disturbance through efforts such as the Children's Policy Academy and grant partnerships with other child-serving state agencies and community entities.

Goal 4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
Strategies for FY07 in the DMHDD Three Year Plan include:
- to collaborate with the DOH, BADAS, to share information and plan interdepartmental activities to address the integrated screening, assessment and treatment/service needs of persons with co-occurring disorders of mental illness and substance abuse/dependence.

Goal 4.4: Screen for mental disorders in primary health care, across the life span…
Strategies for FY07 in the DMHDD Three Year Plan include:
- to educate primary care providers and human service professionals about mental health issues across the life span by providing informative materials that include screening tools and referral resources for use by primary care physicians and human service professionals.

iv. Criterion 4 Targeted Services to Rural and Homeless Populations

Homeless
The TCPP provides a continuum of services for all eligible children with SED. Homeless persons who meet the eligibility criteria may receive TennCare using agency addresses, shelter addresses, or Post Office boxes. Homeless children and youth who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost family support groups.

DMHDD funds outreach case management services for homeless children and youth with SED, or at risk of SED, in the Nashville/Davidson County area, the Johnson City area, and in the cities of Chattanooga, Knoxville, Jackson, and Memphis.

Homeless Outreach staff assist in identifying children and youth with SED or who may be at risk of SED. Staff assist the parent(s) in securing needed mental health services for their children and link them with other services needed to keep the family intact and healthy. Outreach staff also refer children for EPSDT screening, which often is the first contact with medical services since birth.

The homeless outreach worker functions as a liaison between the school and the family, facilitates mental health evaluation and treatment, and assists the family in securing more permanent housing. Staff provide assistance until the family becomes linked with more durable, on-going case management, treatment, and social service agencies, is no longer homeless, or no longer accepts services.

Each program has access to flex-funds to purchase a variety of goods and services that are not otherwise funded such as emergency housing, respite, therapeutic summer camp, clothing, school supplies, transportation, and emergency child care.

There are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. One site has sixteen apartments dedicated for women with SMI and their children.

Rural

The U.S. Census Bureau's definition language for rural is "all territory, population, and housing units located outside of urbanized areas and urban clusters". Tennessee will define a "rural county" as one that has 50% or more of its population in a rural area and is not included in the Metropolitan Statistical Areas list. This information is obtained from the 2003 Tennessee Statistical Abstract. Using this definition, there are fifty-nine rural counties in Tennessee.

The TCPP policies require equal eligibility, service coverage, and availability statewide to both urban and rural Tennessee residents. TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations.

Tennessee augments traditional clinical services with alternative services designed to decrease discrimination, engage rural families, and provide opportunities for education and support in areas where there are few community resources.

- A majority of Project BASIC sites are in high-risk, rural areas of the state and are a partnership between a local school and the local CMHC.
- DMHDD involves individuals from rural Tennessee in the planning process and has ensured that there is representation from families, consumers, providers and other advocates from rural areas on all state and regional councils. The Department provides travel and childcare reimbursement to consumers and family members in an effort to encourage participation.
- The Department's Family Support and Advocacy Program, implemented by the TVC, operates statewide and has successfully provided community education in rural areas of the state, based on needs assessment surveys of the community.
- The Mental Health Association of Middle Tennessee, in conjunction with Tennessee Rotary Clubs, sponsors "Erase the Stigma" presentations statewide to school, civic, and community groups. Fifty percent (50%) of presentations are required to be in rural counties.

v. Criterion 5 Management Systems

Financial Resources

Tennessee made available $405,336,429 in capitation payments made monthly to the BHOs for services provided to TennCare Partners Program enrollees through June 30, 2006.

The State continued the financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees that it assumed as of July 1, 1999.

The pharmacy cost for individuals for FY06 in the community amounted to $367,363,853 with medications for individuals during inpatient stays included in the inpatient rates received by the respective inpatient facilities. The pharmacy cost was significantly reduced from the previous year due to TennCare reform, which implemented a five prescription limit, a new Preferred Drug List, and the impact of the Medicare Part D program.

The cost of providing forensic and court-ordered evaluations performed at the five RMHIs and in the community is estimated at $24,764,836 dollars.

DMHDD funded community mental health services, excluding forensic and court ordered evaluations, at $30,836,245. This funding includes the CMHS Block Grant award and other federal grants received by the DMHDD. Further, the five RMHIs expended $99,981,766 above revenue received to provide inpatient mental health services, a 41% increase over FY05.

In total, roughly $928,283,129 was directed for the provision of mental health services to individuals within Tennessee for FY06. The level of funding for mental health services in FY07 may be affected by Medicaid reform.

DMHDD enters into grant agreements to provide a mental health safety net service package to priority population adults who lost TennCare benefits and other service initiatives outside the scope of services provided under the TCPP. Funds are administered through individual grants with CMHAs and other agencies, various Delegated Purchase Authorities for specific services, and additional interdepartmental funds made available to supplement federal grants awarded to Tennessee.

Staffing

DMHDD employs approximately 2,800 staff, 185 in Central Office and the remainder in the five state psychiatric hospitals for approximately 950 service recipients.

The state contract with the medical and behavioral health organizations requires those entities to maintain an adequate provider base to provide services to individuals covered under the benefit plan.

The managed behavioral health care outpatient network consists of around 1,200 credentialed and contracted individual and group providers, exclusive of individual CMHA staff. Additional resources for children and youth include:

- 12 providers of 24-hour residential treatment at 16 locations
- 16 providers of inpatient psychiatric services at 17 locations
- 15 providers of inpatient substance abuse services at 17 locations
- 1 provider of crisis response services for 95 counties

Training
BHO consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee's managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires BHOs to offer the following:
1. an educational plan for providers formulated with input from the BHO Advisory Board; (Boards must have minimum 51% family and consumer membership and consumers and family members must be included as trainers.)
2. cross-training of mental health and substance abuse providers;
3. mental health training for primary care providers; and
4. assurance that providers are appropriately licensed, certified, accredited, approved and/or meet DMHDD standards, whichever is appropriate.

In addition to routine networking opportunities, monitoring and technical assistance, DMHDD provides a variety of training related to implementation of grant-funded services to community providers, family and consumer groups and special grant recipients.

- The Regional Intervention Programs (RIP) provide training as an essential element of the model - parent training of behavior management. Statewide training is provided to new resource coordinators at the Nashville location. RIP staff and statewide RIP technical assistance staff conduct training.

- BASIC project staff receive intensive training at initial implementation and as staff turnover occurs. Technical assistance is available on request and is provided during site visits.

- The Tennessee Respite Network training curriculum for respite providers is offered several times per year or as requested. The network maintains specialized training curricula for problem issues. DMHDD participates in sponsoring an annual Tennessee Respite Conference.

DMHDD staff overseeing service contracts for children and youth provide regularly scheduled training for Homeless Outreach staff and suicide prevention action groups.

Training Providers of Emergency Health Services (See Adult Section)
BHO provider training and DMHDD all-hazards response training includes education about specific responses and interventions for children and adolescents. In FY06, courses in school-based crisis intervention and childhood trauma were added to the list of courses available.

Transformation Activities: (Goal numbers correspond to goals and recommendations in a transformed mental health system as recommended by the President's New Freedom Commission on

Goal 5.4: Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma and acute care.
Strategies for FY07 in the DMHDD Three Year Plan include:

- to collaborate with DCS and Tennessee Voices for Children to develop a trauma counseling training program for community mental health agency counselors who work with victims of child abuse and/or other traumatic events.

Expenditure of 2007 Block Grant Allocation

DMHDD utilizes its Block Grant funding to provide community mental health services designed to promote education, prevention, and early intervention and build a reliable community support service system that emphasizes youth empowerment and resiliency, and family education and support.

CMHS has advised that the 2007 Block Grant Plan project allocations based on the final 2006 award amount of $7,994,515. Approximately 4%, or $343,015, of the award supports administrative functions and Council support. Of the available $7,651,500, slightly more than 32% is allocated for services to children and youth. Currently, eleven private not-for-profit CMHCs and six other community agencies receive federal mental health block grant funds to provide these services.

Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.) Agencies provide services within their service areas.

Some $2,484,200 in CMHS Block Grant funding will be allocated for children and youth services in accordance with Criterion 1, 2, 3, 4, and 5 in the following manner:

BASIC $ 1,600,500

Project BASIC (Better Attitudes and Skills in Children) is an elementary school-based mental health early intervention and prevention service that works with children from kindergarten through third grade. Goals are to enhance awareness and capacity for response of school personnel to the mental health needs of children and to reduce the incidence of adolescent and adult mental health problems. Children with SED are identified and referred for mental health services. Funds support BASIC programs at forty-seven elementary school locations.

Planned Respite Services $ 586,700

This is a program that provides respite services to families of children identified with serious emotional disturbance, or dually diagnosed with SED and mental retardation, who are ages two to fifteen. Respite consultants provide short-term respite and work with the family to identify long-range respite resources. Individualized family respite plans are developed with the family. The consultant enables families to develop community-based respite resources and utilize them effectively.

Funding supports respite services in each of the seven mental health planning regions across the state. Included in the total is $30,000 that supplements state dollars to fund a voucher program to pay for respite services for children ages birth to eighteen of families who reside in Memphis/Shelby County.

Early Childhood Network $ 145,000
This is a collaborative effort on the local level to identify and address the mental health needs of preschool through third grade children through prevention and early intervention strategies. The effort is intended to provide a seamless and comprehensive system to identify and serve, at an early age, children in need of mental health services by networking all local agencies that work with this age group. Funding supports projects in two counties that currently have RIP, BASIC, and Day Care Consultation and have identified gaps in services.

Jason Foundation School Curriculum $ 77,500
In response to the Surgeon General's Call to Action to Prevent Suicide Plan, one of Tennessee's strategies targets providing educational programs for youth that address suicide. The Jason Foundation offers a Triangle of Prevention approach for awareness and prevention of youth suicide. The project addresses youth, parents, teachers, and educators from middle school to college in suicide awareness and prevention through educational programs and seminars.

NAMI-TN Parent Education $ 47,500
"Visions for Tomorrow" is a program that provides education for families of children with SED, utilizing a train-the-trainer model. The goal of the program is to empower parents and guardians to become advocates for their children and to develop tools to help other families in a supportive, educational manner.

Suicide Prevention $ 18,000
Funds supplement state dollars to support the Tennessee Suicide Prevention Network, a statewide coalition that developed and now oversees the implementation of strategies to eliminate/reduce the incidence of suicide across the life span, to reduce the stigma associated with suicide, and educate communities throughout the state about suicide prevention and intervention.

Renewal House $ 4,000
Funding supplements other state dollars to support early intervention and prevention services to children at risk of SED or substance abuse who reside at Renewal House, a residential program for addicted mothers in recovery and their children. Services provide on-site child, family and group counseling for which there is no third-party payer source. Parenting classes, support groups and family enrichment are provided for family preservation. Therapeutic services are also provided for children when evaluations deem such services appropriate.

Cultural Competency $ 5,000
Cultural and Linguistic competency promotion is targeted for mental health agencies, mental health providers and mental health interpreters.

Appendix 7 details the proposed 2007 Block Grant for children and youth services by agency and program.

2) Goals, Targets and Action Plans – Children and Youth

Criterion 1: Comprehensive, Community-Based System of Care

Goal 1.1: To maximize the ability to remain in a community setting by providing coordinated service delivery in the most appropriate, least restrictive environment available.

Name of Performance Indicator: **Psychiatric Admission Rate**
Criterion: 1 – Children and Youth **URS Basic Table 3**
NOM ☐Yes ☑No (State) **Related to Transformation ☐Yes ☑No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	5.0%	4.6%	5%	5%	
Numerator	2,421	2,315			
Denominator	48,237	50,408			

Target: To maintain the number of admissions to psychiatric acute care facilities at a maximum of 5%.
Population: TennCare enrolled children and youth under age 18.
Indicator: Number of admissions to acute inpatient care by children and youth.
Measure: % Numerator: Unduplicated # of children and youth admitted to inpatient psychiatric acute care
Denominator: Unduplicated # of children and youth receiving a TennCare Partners service
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: An acute care admission is defined as one that results in a stay of less than thirty (30) days at any psychiatric hospital.
Significance: A major outcome of a comprehensive, community-based mental health system of care is the reduction of the need for inpatient hospitalization.

Action Plan:
Community treatment options for children with SED have been increased and a dedicated children and youth crisis service initiated. System of Care initiatives have shown positive impact in hospitalization rates of children receiving care.

Goal 1.2: To provide case management services to children and youth with SED receiving benefits under TennCare.

Name of Performance Indicator: Case Management Services
Criterion: 1 – Children & Youth URS Table – N/A
NOM ☐Yes ☑No (State) Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	55%	55%	50%	50%	
Numerator	14,295	15,942			
Denominator	26,013	28,813			

Target: To provide mental health case management services to a minimum of 50% of children and youth with SED.

Population: TennCare enrolled children and youth with SED receiving a TennCare Partners service during FY07.

Indicator: Percentage of children and youth in the priority population who receive a mental health case management service

Measure: % Numerator: Unduplicated # of children with SED receiving a mental health case management service
Denominator: Unduplicated # of children with SED receiving any TennCare Partners service

Source: DMHDD, Division of Managed Care, Research and Analysis Group

Issues: Enrollment of children and youth under the age of eighteen is dependent upon parental or guardian acceptance of the service on behalf of the child.

Significance: Assuring necessary case management services for children and youth with SED is a primary goal of community-based services and a commitment of DMHDD and TennCare.

Action Plan:

Case management is a benefit of TennCare Partners, available to any child based on medical necessity criteria. The vast majority of case management services provided are provided to children and youth with SED.

Financial constraints of the program limit the system's ability to provide case management services to every child with SED in the public system. With the recognition that it is important that children with SED receive access to needed case management services, a target of case management service provision to at least half of those receiving services is maintained.

Criterion 2: Mental Health System Data Epidemiology

Goal 2.1 **To maintain access to services for C&Y with SED receiving behavioral health services through the public managed care system.**

Name of Performance Indicator: **SED Priority Population Access**
Criterion: 2 – Children and Youth **URS Basic Table 14A**
NOM ☐Yes ☑No (State) **Related to Transformation ☐Yes ☑No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	92%	91%	91%	90%	
Numerator	25,320	28,813			
Denominator	27,411	31,573			

Target: To serve a minimum of 90% of children and youth with SED with a current (within one year) assessment of SED.
Population: C&Y enrolled in the TennCare Partners Program and assessed as SED.
Indicator: Number of C&Y with SED served by age, gender and race/ethnicity.
Measure: % Numerator: Unduplicated # of children with SED receiving a behavioral health service
Denominator: Unduplicated # of children with a current assessment of SED.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: None
Significance: Access to services for the under 18 population was not seriously impacted by TennCare waiver or benefit reductions.

Action Plan:
The number of TennCare enrolled children and youth with a current assessment of SED has fluctuated over the past four years – up in FY03 – down in FY04 – up in FY05 - down in FY06. Numerous service initiatives for children have been developed including expansion of intensive case management, Comprehensive Child and Family Treatment Teams for high intensity, time limited services to deter out of home placement or incarceration, and services for special populations of children and adolescents.

There was a nearly 14% increase in the number of children and youth with SED served between FY04 and FY05. Preliminary data shows a projected 10% decrease for FY06. However, the number of children served as a percent of the total number of children assessed as SED has remained fairly constant.

TennCare reform did not have a major impact on access to services for children and youth under the age of 18 since they were exempt from benefit reductions and limitations.

Criterion 3: Children's Services

Goal 3.1. **To offer effective inpatient treatment and continuity of care to maximize community tenure.**

Name of Performance Indicator: **I/P Readmission – 30 Days**
Criterion: 3 – Children and Youth **URS Developmental Table 20**
NOM ☑Yes ☐No **Related to Transformation ☐Yes ☑No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	10.0%	8.8%	9%	9%	
Numerator	70	36			
Denominator	697	408			

Target: Maintain rate of readmission to state psychiatric hospitals within 30 days of discharge to below 10%.
Population: Persons under age 18 discharged from state psychiatric inpatient.
Indicator: Percentage of children and youth discharged from inpatient services in FY06 that are readmitted within 30 days.
Measure: % Numerator: Number of persons age 0-17 who are readmitted to a state hospital (RMHI) within 30 days of discharge.
Denominator: Number of persons age 0-17 discharged from a state hospital (RMHI) during the previous fiscal year.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
DMHDD, Office of Hospital Services
Issues: Readmission is defined as admission to any RMHI within 30 days of a discharge from any RMHI.
Significance: A major outcome of a comprehensive, community-based mental health system of care is the effectiveness of inpatient treatment and the continuity of community care.

Action Plan:
State hospitals accounted for 21.5% of children and youth admissions in FY05, a slight decrease from FY04. The BHOs contract with RMHIs and private psychiatric hospitals to provide inpatient care to children and youth; only two state psychiatric facilities maintain service programs designed for children and youth.

Readmission rates, at least within 30 days, are often dependent upon continuity of care and connection with community treatment and support services. BHO standards of care require a case management assessment prior to discharge, a case manager face-to-face encounter within seven days, and routine outpatient services available within fourteen days. Outpatient providers are required to maintain access logs of initial appointments and performance is monitored by both the BHO and DMHDD.

Managed care systems tend to approve shorter lengths of stay, with utilization review based on need for the acute level of service that can only be provided in a hospital setting. Discharge from that acute level of care can occur regardless of the availability of necessary community services and supports.

DMHDD is currently reviewing readmission data in relation to length of stay to determine if delaying discharge until recommended community services can be arranged can have a positive effect on community longevity and be cost effective.

Goal 3.2. To assure effective inpatient treatment and continuity of care to maximize community tenure.

Name of Performance Indicator: I/P Readmission – 180 Days
Criterion: 3 – Children and Youth URS Developmental Table 20
NOM ☑Yes ☐No Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	18.4%	16%	18%	17%	
Numerator	128	65			
Denominator	697	408			

Target: Decreased rate of readmission to state psychiatric hospitals within 180 days of discharge.
Population: Persons under age 18 discharged from state psychiatric inpatient.
Indicator: Percentage of persons age 0-17 discharged from inpatient services in FY06 that are readmitted within 180 days.
Measure: % Numerator: Number of persons age 0-17 who are readmitted to a state hospital (RMHI) within 180 days of discharge.
Denominator: Number of persons age 0-17 discharged from a state hospital (RMHI) during the previous fiscal year.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: Readmission is defined as admission to any RMHI within 180 days of a discharge from any RMHI.
Significance: Children are best served within the context of family and community.

Action Plan:
While serious emotional disturbances can require hospitalization for necessary adjustments or crisis situations, a major outcome of a comprehensive, community-based mental health system of care is the ability to provide early intervention and family-centered services within the home, school, or other least restrictive environment.

Intensive in-home services for at risk children, education and support for caregivers of children with SED and other emotional and behavioral issues and intensive, specialized interventions by children and youth crisis services programs, all serve to impact the child's ability to remain in the family and community setting.

Goal 3.3: To provide behavioral health services to children and youth that are rated positively by families/caregivers.

Name of Performance Indicator: Client Perception of Care/Outcomes
Criterion: 3 – Children and Youth URS Basic Table 11a
NOM ☑Yes ☐No Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	69%	80%	80%	80%	
Numerator	328	1,147			
Denominator	476	1,435			

Target: To maintain at 80% the consumers/families who report positively about service outcomes for their children.
Population: C&Y receiving services through the public mental health system in FY07.
Indicator: Percentage of persons submitting a positive survey response on outcomes.
Measure: % Numerator: Unduplicated # of individuals reporting positive response to survey question on outcomes.
Denominator: Unduplicated # of individuals responding to child/adolescent survey/family.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: None
Significance: A positive perception of care increases the likelihood of continued service acceptance and positive movement toward recovery.

Action Plan:
The highest goal of any service system is to attain the best possible outcome for the service recipient and his or her family. Since FY03, the percentage on the positive outcome measure has been at 69%. These correlate with 87% and 82% rates of participation in treatment planning. It is noted that the stratified sample for FY04 had a 22% response rate.

In FY05, DMHDD made a decision to no longer use the mail out method to conduct consumer surveys. A paper survey was given to any willing service recipient with a scheduled appointment at any of twenty-two CMHAs within a twenty-day period. This significantly increased both the number of surveys completed and the response rate. This method will continue for FY06.

In early FY07, DMHDD will pilot the Tennessee Outcomes Measurement System (TOMS) - a consumer outcomes survey that will provide additional consumer and family feedback for domains of Quality of Life, Functioning, Symptoms and Substance Use, as well as information regarding living situation, employment/school and criminal justice issues.

The TOMS will eventually include both a Youth Survey for ages 13-17 and a Family/Caregiver Survey for service recipient children from 5-12 and provide data on all persons receiving publicly funded behavioral health services through CMHAs providing contracted services in the state. A computerized survey system, TOMS will include the most current survey questions developed through the Data Infrastructure Grant process on an annual basis.

Other DMHDD contract programs also include annual surveys and program questionnaires requesting feedback on the effectiveness of services or educational events.

Goal 3.4: To increase availability of behavioral health interventions having consistent, scientific evidence showing improved consumer outcomes.

Name of Performance Indicator: Number of EBPs Available
Criterion: 3 – Children and Youth URS Developmental Table 16
NOM ☑Yes ☐No Related to Transformation ☑Yes ☐No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	2	3	3	3	
Numerator					
Denominator					

Target: To maintain availability to evidenced based practices.
Population: Children and Youth assessed as SED.
Indicator: Number of CMHS-defined evidenced based practices being provided in Tennessee.
Source: DMHDD, CMHA Survey, BHOs
Issues: States may be providing other services qualified to be evidenced based practices that are not included in the CMHS table listing.
Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Action Plan:
The URS Table 16 list of Evidenced Based Practices for children includes:

1. Therapeutic Foster Care
2. Multi-Systemic Therapy
3. Family Functional Therapy

Therapeutic foster care is provided by the Department of Children's Services for children in state custody through contract grants with community providers. By way of a provider agency survey in 2005, it was reported that multi-systemic therapy and family functional therapy was also practiced. An annual provider survey will be used to assess the use of these models across the state.

Goal 3.5: To provide behavioral health interventions for which there are consistent, scientific evidence showing that they improve consumer outcomes.

Name of Performance Indicator: Number Receiving EBP Service
Criterion: 3 – Children and Youth URS Developmental Table 16
NOM ☑Yes ☐No Related to Transformation ☑Yes ☐No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Tx Foster Care	N/A	411			
MST	N/A	3,230			
FF Therapy	N/A	1,060			
TOTAL	**N/A**	**4,701**	**①5,000**	**5,300**	

① New FY06 projection based on FY05 survey information.

Target: To increase by 300 the number of children and youth receiving an Evidenced Based Practice.
Population: C&Y assessed as SED receiving a TennCare Partners service or DCS provided service during FY06.
Indicator: Number of children and youth receiving an evidenced based practice as defined by CMHS.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: States may be providing other services qualified to be evidenced based practices that are not included in the CMHS table listing.
Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Action Plan:
DMHDD supports and promotes the development and implementation of evidenced based practices throughout the behavioral health system. Multi-system therapy is mandatory in the current BHO contracts.

For data to be reported in the December 1, 2006 URS Tables, an agency survey method will be used to determine EBP services provided, assess fidelity measure use, and at least estimate the number of persons served, although demographics beyond age are not expected to be reported.

Technical assistance will be sought to investigate other reporting methods. Currently, no other method appears to be a viable alternative to an annual provider survey. Upon receipt of survey results in 2005, all three listed EBPs were being offered by a number of providers across the state.

Goal 3.6 To maintain access to services for C&Y receiving behavioral health services through the public managed care system.

Name of Performance Indicator: Increased Access to Services
Criterion: 3 – Children and Youth URS Basic Table 2A
NOM ☑Yes ☐No Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	48,237	50,408	46,000	47,000	
Numerator					
Denominator					

Target: To serve 1,000 additional children and youth in FY07.
Population: Children and youth under 18 enrolled in the TennCare Partners Program
Indicator: Unduplicated number of C&Y served by age, gender and race/ethnicity.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: None
Significance: The impact of TennCare reform is not expected to impact the under age 18 population regarding access to services.

Action Plan:
TennCare enrollment remains available for children and youth under age 21 who meet eligibility requirements for Medicaid. Their benefits have not changed and all services are available without limits as deemed medically necessary or referred by EPSDT screening. The number of children and youth receiving behavioral health care services through TennCare rose an average of 6% a year until FY05. However, preliminary data shows a decrease in the number of services to persons under age 18 in FY06.

The TOMS consumer survey system, currently being piloted, will enable us to count children receiving services through other non-TennCare publicly funded contracts.

Goal 3.7: To ensure substance abuse service access for children and youth with co-occurring disorders (COD) of SED and substance abuse.

Name of Performance Indicator: Co-occurring Services
Criterion: 3 – Children and Youth URS Basic Table 2A
NOM ☐Yes ☑No (State) Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	34%	80%	80%	80%	
Numerator	632	1,398			
Denominator ①	1,830	1,733			

① Children and youth under age 18 with SED and any other diagnosis of substance abuse.

Target: To increase the number of children and youth with COD who are accessing substance abuse services.

Population: Children and youth enrolled in TennCare diagnosed with SED and any substance abuse diagnosis.

Indicator: Percent of children with COD who receive a substance abuse service through the behavioral managed care system.

Measure: % Numerator: Unduplicated # of children and youth under 18 receiving a substance abuse service.
Denominator: Unduplicated # of children and youth with COD.

Source: DMHDD, Division of Managed Care, Research and Analysis Group

Issues: The Bureau of Alcohol and Drug Abuse Services has data for persons under eighteen with a mental health diagnosis, but do not specify SED for alcohol and drug services provided under the Substance Abuse Block Grant. Therefore, data is for children receiving services under TennCare.

Significance: While integrated services is the optimal service goal, the ability to access appropriate inpatient and outpatient substance abuse services is critical for those with COD.

Action Plan:

The Bureau of Alcohol and Drug Abuse Services documents services for persons under eighteen with a mental health diagnosis, but it does not specify those with SED for alcohol and drug services provided under the Substance Abuse Block Grant. The Bureau serves a minimal number of children and youth with a mental health diagnosis in treatment services apart from the managed care system. Therefore, data is for children receiving services under TennCare.

Providers are often reluctant to label children with a substance abuse diagnosis, but once diagnosed, appropriate treatment should be forthcoming. Numbers reported include those receiving an inpatient or outpatient service.

Criterion 4: Targeted Services to Rural and Homeless Populations

Goal 4.1 **To assure equitable access to behavioral health services through the public managed care system.**

Name of Performance Indicator: **Rural Children and Youth Access**
Criterion: 4 – Children and Youth **URS Table – N/A**
NOM ☐Yes ☑No (State) **Related to Transformation ☑Yes ☐No**

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	95.8%	89.2%	90%	90%	
Numerator	① 9,937	② 6,783			
Denominator	10,371	7,601			

① FY04 data is based on encounter data from individuals residing in seventy-seven counties designated as rural. ② Data from FY05 on is based on encounter data from individuals residing in fifty-nine counties designated as rural.

Target: To serve a minimum of 90% of rural C&Y with a current assessment of SED.
Population: C&Y with SED residing in a rural county and enrolled in TennCare Partners.
Indicator: Percent of children and youth who live in designated rural counties and receive a behavioral health service through the managed care program.
Measure: % Numerator: Unduplicated # of rural children and youth under 18 receiving a service.
Denominator: Unduplicated # of rural children and youth with a current (within one year) assessment of SED.
Source: DMHDD, Division of Managed Care, Research and Analysis Group
Issues: As of FY05, 59 of 95 counties in Tennessee are designated as rural,
Significance: Assuring access to mental health services for C&Y with SED living in rural areas.

Action Plan:
The 2000 census description of urban/rural and metropolitan statistical areas decreased Tennessee's rural population demographic and resulted in the loss of a rural county designation for eighteen counties.

Due to a reconfiguration of counties defined as rural, the percentage of the total number of TennCare enrollees assessed as SED and living in a rural county dropped from 38% in FY04 to 24% in FY05. That percentage remains the same for FY06.

The data shows a significant decrease in the percent of rural enrollees receiving a behavioral health service since FY04. However, the perceived decreases may not relate to rural county redesignation - percentages for the two years preceding FY04 averaged 91.8%.

DMHDD continues to monitor rural provider availability to ensure reasonable access to medical and behavioral health care and requires the BHOs to submit plans of correction when access indicators are not met. Rural accessibility will continue to be monitored to determine any trends in rural enrollee service access.

Goal 4.2: To provide outreach to homeless families with children to promote assessment and needed service access.

Name of Performance Indicator: C&Y Homeless Outreach
Criterion: 4 – Children and Youth URS Table – N/A
NOM ☐Yes ☑No (State) Related to Transformation ☑Yes ☐No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Projected*	*FY07 Target*	*FY07 Attained*
Performance Indicator	68.6%	47.3%	50%	55%	
Numerator	210	115			
Denominator	306	243			

Target:: To increase access of homeless families to appropriate community resources.
Population: Homeless parents with children suspected of SED or at risk of SED.
Indicator: Percentage of family members accessing needed services after referral by the C&Y Homeless Outreach Team.
Measure: % Numerator: Number of families accessing resource.
Denominator: Number of referrals by Team.
Source: C&Y Homeless Outreach Project Annual Report
Issues: Other team referrals not included in this indicator are for TennCare enrollment, EPSDT screening, housing services, legal services, flex funds and emergency food and/or clothing.
Significance: Children of homeless families are at increased risk of experiencing physical neglect and/or developing behavioral and/or emotional problems or substance abuse.

Action Plan:
The goals of this program are to provide outreach services for homeless families to identify children and youth who may be SED or who may be at risk of SED, assist the parent in securing needed mental health services for their children (and often themselves), and link the parents with other services needed to keep the family intact and healthy.

While assessment and service access are available for homeless families with children with SED, or at risk of SED, follow-up with a referral is dependent on follow-through by the parent(s) and system capacity. Homeless Outreach staff training includes strategies to maximize the willingness and ability of parents to follow-through on recommended referrals.

The goal above measures referral and resource access in three combined areas: 1) referral of a parent for a mental health evaluation, 2) referral of a parent for vocational/educational training, and 3) referral of a child for a mental health evaluation.

Criterion 5: Management Systems

Goal 5.1: To ensure a proportion of Block Grant funding for early intervention and prevention services for children and youth.

Name of Performance Indicator: Early Intervention and Prevention
Criterion: 5 – Children and Youth URS Table – N/A
NOM ☐Yes ☑No (State) Related to Transformation ☐Yes ☑No

Fiscal Year	*FY04 Actual*	*FY05 Actual*	*FY06 Actual*	*FY07 Target*	*FY07 Attained*
Performance Indicator	24.7%	23.6%	22.8%	20%	
Numerator	1,956,500	1,823,000	1,745,500		
Denominator	7,900,900	7,730,700	7,647,500		

Target: To maintain at least 20% of Block Grant funding for early intervention and prevention services.
Population: Children and Youth with SED, or at risk of SED
Indicator: Percentage of block grant funds being used for prevention and early intervention services.
Measure: % Numerator: Amount to be allocated for prevention and early intervention services
Denominator: Total amount of block grant funding minus administrative costs
Source: DMHDD Block Grant Budget Allocation
Issues: Allocations based on continued ability to expend Block Grant funding for non-treatment services.
Significance: Children and youth under eighteen comprise nearly 25% of Tennessee's population. Early prevention and intervention services are considered most important to avoid more serious emotional and/or behavioral problems.

Action Plan:
DMHDD has targeted both Block Grant and Departmental funding toward services aimed at prevention and early identification of children and youth with behavioral and/or emotional problems. The K-3 program, BASIC, and the Regional Intervention Program (RIP) were developed in Tennessee more than twenty years ago and have expanded across the state. BASIC has been nationally recognized by the American Psychiatric Association and RIP has been extensively researched as a best practice. A number of states seek training from Tennessee to replicate these programs.

While supporting treatment, education, and other child and family support services, DMHDD is committed to the philosophy of prevention and early intervention. Dollars include allocations for BASIC and the Early Childhood Network.

APPENDICES

APPENDIX 1

TENNESSEE STATE MENTAL HEALTH PLANNING AND POLICY COUNCIL MEMBERSHIP ROSTER

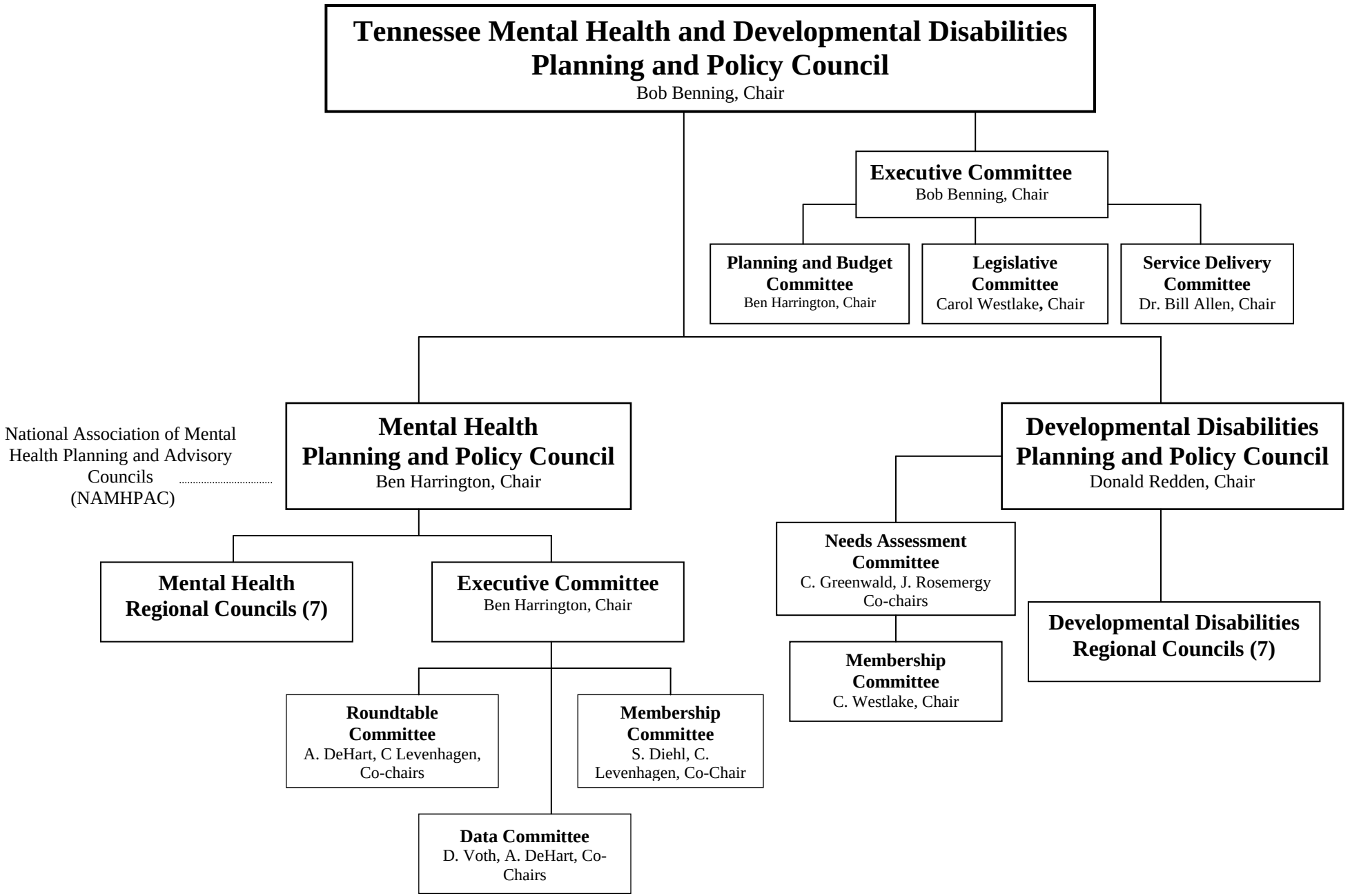
NAME	*CATEGORY*	*POSITION*	*AGENCY OR ORGANIZATION REPRESENTED*	*ADDRESS, PHONE & FAX*
Austin, Stephanie	Provider	Regional Chair	Region III - Chair	Valley BH System, 2200 Morris Hill Road, Chattanooga 37421; Phone: 423.894.4220, Fax: 423.499.2320.
Baker, Donna	Consumer	Delegate	Region VI	58 Dixon Street, Apartment D-30, Lexington 38351; Ph: 731.967.3549
Bertrand, Anita	Advocate	Necessary Stakeholder	Director, State Public Policy Office, Mental Health Associations of TN	2416 21st Ave S., Suite 201, Nashville, 37212-5318; Ph: 615.242.7122; Fax: 615.242.9637.
Besmann, Wendy	Consumer	Delegate	Region II	9119 Solway Ferry Road, Oak Ridge, 37830; Ph: 865.927.3028; Fax: 865.927.0631.
Blackburn, Dick	Provider	Necessary Stakeholder	TN Association of Mental Health Organizations	42 Rutledge St., Nashville 37210-2043; Ph: 615.244.2220; Fax: 615.254.8331.
Blackford, Joel	State	Mandated	Department of Human Services - Division of Vocational Rehab.	Program Coordinator; Citizens Plaza Bldg., 11th Floor, 400 Deaderick St., Nashville 37248-6000; Ph: 615.313.4898.
Bryson, Charlotte	Advocate	Necessary Stakeholder	TN Voices for Children	1315 8th Ave S, Nashville, 37203; Ph: 615.269.7751; Fax: 615.269.8914.
Carden, Archie	State	Necessary Stakeholder	TN Department of Children's Services	College Park Drive, Suite A; Columbia, TN 38401. Phone: (931) 380-2587, ext 6065. Fax: (931) 490-6118.
Caudill, Jeanne	State	Necessary Stakeholder	TN Commission on Aging & Disability	Assistant Director, Andrew Jackson Bldg., 8th Floor, Suite 825; 500 Fifth Avenue, N; Nashville, 37243; Ph: 614.741.2056.
Coats, Marilou	Family / SMI	Delegate	Region III	3621 Glendon Drive, Chattanooga, 37411; Ph: 423.698.2384; Fax: 423.698.6617.
Cobb, Brad	Family / SMI	Delegate	Region VII	P O Box 40168, Memphis 38174; Ph: 901.725.0305; Fax: 901.725.0306.
Copas, Linda	State	Mandated	Dept. of Education - Division of Special Ed.	AJ Tower, 8th and James Robertson, 5th floor, Nashville 37243; Ph: 615.741.7790, Fax: 615.532.9412.
Cox, Carol	Provider	Regional Chair	Region II - Chair	Ridgeview, 240 W. Tyrone Road, Oak Ridge, 37830; Ph: 865.481.6170, Ext. 1131; Fax: 865.481.6179.
Currey, Bonnie	Provider	At large	Immediate Past Chair	A.I.M. Center,1903 McCallie Ave., Chattanooga, 37404; Ph: 423.624.4800; Fax: 423.622.8102.
DeHart, Al	Provider	Delegate	Region V	Centerstone, 721 Highway 46, Dickson 37055; Ph: 615.446.4357; Fax: 615.446.3760.
Diehl, Sita	Family / SED	Necessary Stakeholder	Executive Director, NAMI-Tennessee	1101 Kermit Drive, Suite 605, Nashville 37217; Ph: 615.361.6608; Fx: 615.615.361.6698
Dillon, Debra	Provider	Regional Chair	Region VII - Chair	Southeast MHC, 3810 Winchester Road, Memphis 38181; Ph: 901.312.7518; Fax: 901.369.1433.
Ewing, Rhonda	Family / SMI	At large	At-Large	239 North Parkway, Suite C, Jackson 38305; Ph: 731.984.8599; Fax: 731.984.8575
Falkner, Sherry	Family / SMI	Delegate	Region I	3608 Cimarron Drive, Johnson City, 37601; Ph: 423.282.8844; Fax: 509.461.7596.
Fox, Anthony	Consumer	Necessary Stakeholder	Executive Director, TN MH Consumers Association	480 Craighead Street, Suite 200, Nashville 37204; Ph: 615.250.1176; Fax: 615.383.1176.

APPENDIX 1

TENNESSEE STATE MENTAL HEALTH PLANNING AND POLICY COUNCIL MEMBERSHIP ROSTER

Godsey, Teresa	Consumer	Delegate	Region I	2802 Plymouth Road, #209; Johnson City 37601; Ph: 423.926.1693.
Griffin, Jim	Advocate	Delegate	Region II	7921 Neubert Springs Road, Knoxville 37920; Ph: 865.609.2490; Fax: 865.609.2543.
Harper, Brenda	Provider	Delegate	Region V	Volunteer-Cumberland, 1404 Winter Drive, Lebanon 37087; Ph: 615.444.4300
Harrington, Ben	Advocate	At large	Council Chair	MHA of East TN, P O Box 32731, Knoxville 37930-2731; Ph: 865.584.9125; Fax: 865.824.0040.
Harrington, Pam	Family / SMI	Regional Chair	Region VI - Chair	5115 Paris-Murray Road, Paris 38242l; Ph: 731.642.7665.
Jordan, Clarence	Consumer	Regional Chair	Region IV - Chair	1101 Kermit Drive, Suite 605, Nashville 37217; Ph: 615.361.6608; Fx: 615.615.361.6698
Lawson, Vickie	State	Mandated	Department of Human Services - Social Services	400 Deaderick Street, Citizens Plaza, 14th Floor, Nashville 37243; Ph: 615.313.4784, Fax: 615.532.9956.
Lewis, Linda	Consumer	Delegate	Region VI	207 Forrest, P. O. Box 474, McKenzie 38201; Phone: 731-352-7833.
McKenzie, Mamie	Family / SMI	Delegate	Region IV	TN Voices for Children, 1315 8th Ave S, Nashville, 37203; Ph: 615.269.7751; Fax: 615.269.8914.
Miller, Jeanine	State	Mandated	Department of Correction	Director, Mental Health, DOC; Rachel Jackson Bldg., 4th Floor, Nashville, 37243; Ph: 615.741.1000, Ext. 8163 Fax: 615.741.1055
Myszka, Michael	State	Mandated	Bureau of TennCare (Medicaid)	Director for Behavioral Health and Children's Services; DOH, 706 Church St, 6th Floor, Nashville, 37247; Ph: 615.741.8142; Fax: 615.741.0064.
ONeal, Linda	State	Necessary Stakeholder	TN Commission on Children & Youth	710 James Robertson Parkway, Nashville, 37243-0800; Ph: 615.741.2633; Fax: 615.741.5956.
Page, Joe	Provider	Regional Chair	Region I - Chair	Frontier Health, 26 Midway Street, Bristol, TN 37620; Ph: 423-989-4691
Reigel, Karen	Consumer	Regional Chair	Region V - Chair	1840 Memorial Drive, Clarksville 37043; Ph: 931.905.0933; Fax: 931.906.0355.
Shearon, Lorrie	State	Mandated	TN Housing Development Agency	Director, Research, Planning and Technical Services; 404 James Robertson Pkwy, Nashville, 37243; Ph: 615.741.9671; Fax: 741.9634.
Simpson, Zoe	Consumer	Delegate	Region VII	3640 Pleasant Hollow, Apt. 5, Memphis 38115; Ph: 901.360.0953
Smith, Rhonda	Family / SED	At large	At-Large	480 Craighead Street, Suite 200, Nashville 37204; Ph: 615.250.1176; Fax: 615.383.1176.
Thompson, Verdine	Consumer	Delegate	Region III	1110 Sioux St, Athens, 37303; Ph: 423.745.4796; Fax: 423.745.1797.
Voth, Don	Advocate	At large	Council Vice-Chair	334 Buena Vista Place, Memphis 38112; Ph: 901.725.2258; Fax: Same.
Whitlock, Marthagem	State	Mandated	State MH Agency, TDMHDD	425 Fifth Avenue N, CHB-3, Nashville 37243; Ph. 615.532.6744; Fax: 615.532.6514.
Williams, Pat	Family / SMI	Delegate	Region IV	4301 Elkins Avenue, Nashville 37209; Ph: 615.386.0204; Fax: 615.259.7594.

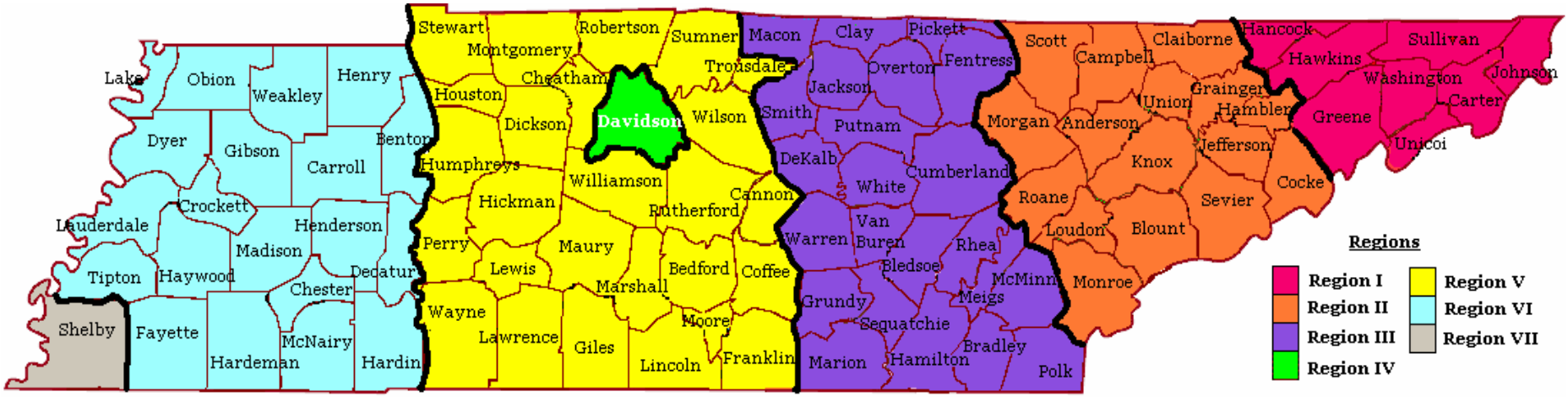
APPENDIX 2



Revised 8.18.06

APPENDIX 3.

TDMHDD PLANNING REGIONS



APPENDIX 4.

TENNESSEE MENTAL HEALTH PLANNING AND POLICY COUNCIL BYLAWS

ARTICLE I

NAME

The name of the organization shall be the Tennessee Mental Health Planning and Policy Council (hereinafter referred to as "the Council").

ARTICLE II

PURPOSE

Pursuant to Public Law 102-321 and T.C.A. Sections 33-2-202 and 33-2-203, the principal purpose of the Council is to provide citizen participation to assist and advise the Tennessee Department of Mental Health and Developmental Disabilities (DMHDD) in planning, policy development, and oversight of the state's comprehensive mental health service system for persons of all ages with mental health needs including adults with serious mental illness (SMI) and children and youth with serious emotional disturbance (SED). More specifically:

2.1 The Council shall review the annual Mental Health Block Grant plan and make recommendations.

2.2 The Council shall serve as an advocate for adults with SMI and for children with SED and other individuals with mental illnesses or emotional problems by providing public mental health education and awareness activities and promoting non-discriminatory policies and practices.

2.3 The Council shall monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state including review of monitoring and evaluation reports pertaining to the implementation of the state's mental health program.

2.4 The Council shall advise the DMHDD Planning and Policy Council on the three-year plan including the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families, and such other matters as the Commissioner of DMHDD or the DMHDD Planning and Policy Council may request.

2.5 The Council shall provide information and advice to the Department on policy, formulation of budget requests, development and evaluation of services and supports, and on other matters as requested by the Commissioner of DMHDD or the DMHDD Planning and Policy Council.

ARTICLE III

MEMBERSHIP AND MEETINGS

3.1 Voting Membership

The Council is to provide citizen participation in policy development and planning and shall be representative of persons of all ages with mental health needs including service recipients, family members of service recipients, advocates for children, adults, and the elderly, service providers, state agencies, and other affected persons and organizations. At least a majority of Council membership shall be current or former service recipients and family members of service recipients of all ages.

All Council powers, business, and affairs shall be exercised by or under the authority of the Council membership.

Council membership shall not exceed forty-five (45) voting members except as necessary to meet a majority of service recipients and family members or to maintain mandated representation. The Council shall promote cultural and geographic diversity within the membership.

The membership of the Council shall include representation from:

- ✓ Department of Mental Health and Developmental Disabilities (1)
- ✓ Department of Education (1)
- ✓ Department of Human Services, Social Services (1)
- ✓ Department of Human Services, Vocational Rehabilitation Services (1)
- ✓ Department of Correction (1)
- ✓ Department of Finance and Administration, Bureau of TennCare (Medicaid) (1)
- ✓ Tennessee Housing Development Agency (1)
- ✓ Tennessee Commission on Aging and Disability (1)
- ✓ Department of Children's Services (1)
- ✓ Tennessee Commission on Children and Youth (1)
- ✓ Tennessee Voices for Children (1)
- ✓ Tennessee Mental Health Consumers Association (1)
- ✓ National Alliance for the Mentally Ill of Tennessee (1)
- ✓ Tennessee Mental Health Association (1)
- ✓ Tennessee Association of Mental Health Organizations (1)
- ✓ Regional Mental Health Planning and Policy Council Delegates (21)

  (Each regional council shall be represented by three (3) delegates. One designee shall be the Regional Council Chair. A minimum of two (2) delegates shall be current or former service recipients ages sixteen (16) and above and/or family members or guardian/conservators of service recipients of all ages. Delegates are to be selected annually by April 1.)

- ✓ At-large Members (4-9) - consumers and family members sufficient to assure 51% or better Council majority, cultural diversity, and/or geographical representation.

3.2 Invited Participants

The membership of the Council may include representative(s) of the following constituencies as Invited Participants in Council meetings, committees, and other Council activities:

- ✓ Tennessee Association of Residential Rehabilitative Services
- ✓ Tennessee Coalition for the Homeless
- ✓ Tennessee Conference on Social Welfare
- ✓ Tennessee Council for the Hearing Impaired
- ✓ Disability Law & Advocacy Center of Tennessee (DLAC)
- ✓ Tennessee Regional Mental Health Institutes
- ✓ Behavioral Health Organizations
- ✓ Managed Care Organizations
- ✓ Tennessee Association of Alcohol & Drug Abuse Services
- ✓ Department of Health, Bureau of Alcohol and Drug Abuse Services
- ✓ Department of Veterans Affairs
- ✓ Tennessee General Assembly

3.3 Nomination of Membership and Officers

The Membership Committee shall have the responsibility to make nominations for the Council membership and slate of officers. The Executive Committee shall appoint the Chair of the Membership Committee. The Committee will include a Council member from each of the mental health planning regions. Not more than one member shall be chosen from any agency or organization named in Article III, Section 3.1. Not more than three (3) members of the Membership Committee shall be providers of behavioral health care services or state employees.

The Membership Committee shall solicit suggestions for Council membership from each of the constituencies named in Article III, Section 3.1. The Membership Committee will complete its nominations for new membership annually by May 1. Nominations may also be received from the floor at the fourth quarterly Council meeting.

3.4 Election of Officers and Membership

The members shall vote on the nominations at the fourth quarterly meeting of the fiscal year. The members shall vote in person. Each member is entitled to one vote. The slate of approved nominees will be submitted to the Commissioner of DMHDD with a recommendation for appointment to the Council.

3.5 Term

On July 1, 2005, Council membership will be appointed on a staggered-term basis: 1/3 of the membership for a one (1) year term; 1/3 of the membership for a two (2) year term; and 1/3 of the membership for a three (3) year term. Thereafter, all terms will be for (3) years.

Regional Chairs and delegates shall serve a term that coincides with their regional status as Council Chair and/or delegate. If this status changes, the new Chair and/or delegate will serve the remainder of the Council term.

3.6 Council Meeting Time and Place

The Council meetings shall be held quarterly. The Council Chair shall designate the time and place for any regular or special meeting in a notice sent to the membership and invited participants.

3.7 Special Meetings of the Council

Special meetings of the Council may be called by the Chair or Vice Chair. Special meetings must be preceded by at least five days notice of the date, time, place, and purpose of the meeting.

3.8 Voting

Voting members shall include appointed representatives of the constituency groups cited in Article III, Section 3.1 and other stakeholders as needed to meet statutory requirements.

The affirmative vote of the members present is the act of the Council. A member who is present at a meeting of the Council when action is taken is deemed to have assented to such action unless: 1) Such member objects at the beginning of the meeting (or promptly upon arrival) to holding the meeting or transacting business at the meeting, or 2) such member's dissent or abstention from the action taken is entered in the minutes of the meeting. All actions passed shall be by majority vote.

3.9 Proxy Voting

A voting member who is unable to attend may designate a substitute representative with proxy privileges. The member and his/her substitute must belong to the same constituency group as defined in Article III, Section 3.1. Intent to send a proxy shall be communicated to the Council Chair or DMHDD within three (3) days of the scheduled meeting, if at all possible. Each substitute must notify the Council Chair or DMHDD staff of his/her presence at the start of each meeting and record the substitute status by signing the meeting attendance list. Abuse of proxy privileges may result in termination of voting member status (see 3.12).

3.10 Resignation

A voting member may resign by delivering written notice to the Council, either via DMHDD staff assigned to the Council or directly to the Chair. A resignation is effective when the notice is delivered unless the notice specifies a later effective date.

3.11 Vacancy

When the vacancy of a voting member, for any cause, will result in a quarterly delay of action, the Council vacancy shall be filled for the unexpired term by vote of the Executive Committee of the Council on nomination(s) proposed by the Membership Committee, in conformity with Article III, Sections 3.1 and 3.2, and announced at the next regularly scheduled meeting of the Council.

3.12 Termination

Any voting member who misses two (2) consecutive meetings without good cause and without prior notification shall be subject to termination with replacement in conformity with Article III, Sections 3.1, 3.2, and 3.11. Any member subject to termination shall be advised in writing and given the opportunity to appeal to the Chair of the Council before the next regularly scheduled meeting of the Council.

A voting member who designates a substitute with proxy shall be considered attending the meeting if he/she advised the Chair or DMHDD staff of the good cause within three (3) days of the meeting. A voting member who sends a proxy more often than he/she attends, even with good cause, is subject to having his/her voting membership reviewed by the Membership Committee.

ARTICLE IV

OFFICERS

4.1 Officers
The officers of the Council shall be the Chair, Immediate Past Chair, and Vice Chair.

4.2 Resignation
An officer may resign by delivering written notice to the Council via DMHDD staff assigned to the Council or directly to the Chair. Such resignation is effective when delivered unless notice specifies a later effective date.

4.3 Vacancy
Any vacancy may be filled for the unexpired term by majority vote at the next scheduled Council meeting in conformity with Article III, Sections 3.1, 3.2 and 3.3. The names of the approved nominee(s) will be submitted to the Commissioner of DMHDD with a recommendation for appointment to the Council.

4.4 Duties of the Chair
The Chair shall have general management of the business and affairs of the Council and shall perform such other duties as the Council may from time to time prescribe.

4.5 Duties of the Immediate Past Chair
The Immediate Past Chair shall assist the Chair with the management of Council business and affairs, offering advice and consultation to the Chair, the Council, the Executive Committee, Standing Committees, and the Regional Planning and Policy Councils as necessary.

4.6 Duties of the Vice Chair
The Vice Chair shall assist the Chair in the management of the Council to include presiding at meetings in the absence of the Chair. The Vice Chair is considered the Chair-elect subject to the nominating process outlined in Section III, Article 3.3

4.7 Term
The term of office for all officers shall be two (2) fiscal years, beginning July 1 of each year. An officer may be re-elected for one (1) consecutive two-year term.

ARTICLE V

COMMITTEES

5.1 Executive Committee
The Executive Committee shall be comprised of the Officers of the Council, the Chairs and/or Co-chairs of the Council Committees, the Chairpersons of the Regional Planning and Policy Councils, and at-large members. At least a majority of the Committee shall be comprised of service recipients and family representatives. Members-at-large may address cultural diversity, geographical representation, or be required to meet the majority requirement.

The Executive Committee shall conduct necessary business of the Council between quarterly meetings. The Executive Committee shall receive and review reports and recommendations from Regional Mental Health Planning and Policy Councils, Council committees, and the DMHDD Planning and Policy Council. Action taken shall be reported at the next quarterly meeting with full disclosure to the Council.

5.2 Appointment of Committees

The Executive Committee shall determine the committees that are needed to operate during the fiscal year. The Chair, with approval of the Executive Committee, shall appoint or approve the Chairpersons of all Council committees by September 1.

Ad hoc members may be appointed to committees for their professional expertise and will serve in non-voting roles. Committees shall be established by September 1.

ARTICLE VI
FISCAL YEAR

The fiscal year of the Council shall be July 1 through June 30.

ARTICLE VII
Bylaw and Charter Amendments

A majority vote of Council members may amend the Bylaws if the proposed amendment(s) have been mailed to all members fourteen (14) days before the meeting.

ARTICLE VIII
Parliamentary Authority

Robert's Rules of Order Revised shall be observed in meetings of the Council.

EXECUTIVE COMMITTEE APPROVED: DATE: May 19, 2005

MENTAL HEALTH PLANNING AND POLICY COUNCIL

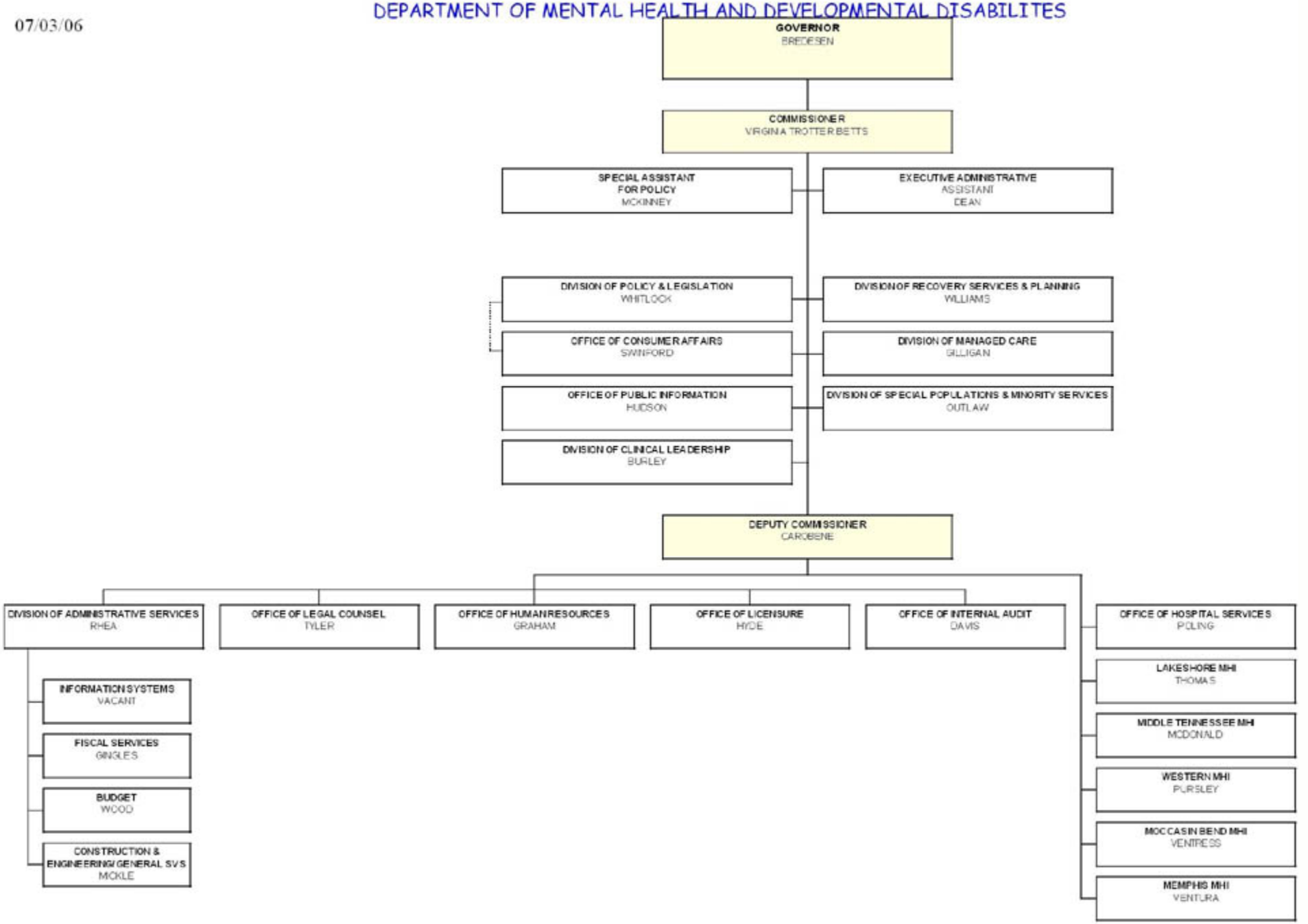
APPROVED: DATE: May 20, 2005

EFFECTIVE DATE: July 1, 2005

Appendix 5

07/03/06

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITES



APPENDIX 6. PROPOSED ALLOCATION OF 2007 BLOCK GRANT FUNDS FOR ADULT SERVICES

CMHC	Assisted Living	Criminal Justice	BRIDGES / Cultural Competency	Older Adult	Peer Support Center	Total
Frontier	140,000	40,000	0	70,000	462,300	$712,300
Cherokee	0	0	0	0	51,400	$51,400
Ridgeview	0	0	0	0	308,200	$308,200
HR McNabb	0	50,000	0	0	113,200	$163,200
Peninsula	0	0	0	0	154,100	$154,100
Volunteer	0	90,000	0	70,000	986,500	$1,146,500
Fortwood	0	0	0	0	113,200	$113,200
Centerstone	0	105,000	0	70,000	726,200	$901,200
Carey	0	40,000	0	0	308,200	$348,200
Pathways	0	0	0	0	205,500	$205,500
Quinco	0	0	0	0	205,500	$205,500
Professional Counseling	0	0	0	0	205,500	$205,500
Southeast	0	0	0	0	113,200	$113,200
Frayser	0	0	0	70,000	0	$70,000
OTHER AGENCY						
Mental Health Association	0	0	21,800	0	0	$21,800
Mental Health Cooperative	35,000	50,000	0	0	0	$85,000
Park Center	35,000	0	0	0	0	$35,000
Shelby Co. Govt.	0	101,000	0	0	0	$101,000
TN Disability Coalition	0	0	226,500	0	0	$226,500
Total Adult	**$ 210,000**	**$ 476,000**	**$ 248,300**	**$ 280,000**	**$3,953,000**	**$ 5,167,300**
					Total C&Y	$2,484,200
					Total Both	**$ 7,651,500**
					Admin. 4%	$ 343,015
					TOTAL BG	**$ 7,994,515**

APPENDIX 7. PROPOSED ALLOCATION OF 2007 BLOCK GRANT FUNDS FOR CHILDREN AND YOUTH SERVICES

CMHC	BASIC	Renewal Hs/ Cult. Comp.	Early Childhood Network	Jason/ NAMI/ TSPN	Planned Respite	Total
Frontier	281,557	0	0	0	81,112	$362,669
Cherokee	70,028	0	0	0	0	$70,028
Ridgeview	40,016	0	0	0	48,112	$88,128
Volunteer	280,110	0	72,500	0	184,040	$536,650
Fortwood	40,016	0	0	0	0	$40,016
Centerstone	263,887	0	72,500	0	81,112	$417,499
Carey	120,048	0	0	0	0	$120,048
Pathways	120,047	0	0	0	0	$120,047
Quinco	224,727	0	0	0	81,112	$305,839
Professional Counseling	160,064	0	0	0	0	$160,064
Frayser	0	0	0	0	81,112	$81,112
OTHER AGENCY						
TN Respite Coalition	0	0	0	0	30,100	$30,100
Renewal House	0	4,000	0	0	0	$4,000
Jason Foundation	0	0	0	77,500	0	$77,500
Crisis Intervention Center	0	0	0	18,000	0	$18,000
MHA of Mid TN	0	5,000	0	0	0	$5,000
NAMI-TN	0	0	0	47,500	0	$47,500
Total C&Y	**$1,600,500**	**$ 9,000**	**$ 145,000**	**$143,000**	**$ 586,700**	**$ 2,484,200**
					Total Adult	$ 5,167,300
					Total Both	**$ 7,651,500**
					Admin. 4%	$ 343,015
					TOTAL BG	**$ 7,994,515**

APPENDIX 8. ABBREVIATIONS GLOSSARY

BADAS	-	Bureau of Alcohol & Drug Abuse Services
BASIC	-	Better Attitudes and Skills In Children
BHO	-	Behavioral Health Organization
BRIDGES	-	Building Recovery of Individual Dreams and Goals through Education and Support
C&Y	-	Children and Youth
CERT	-	Community Emergency Response Team
CHI	-	Creating Homes Initiative
CJI	-	Creating Jobs Initiative
CMHA	-	Community Mental Health Agency
CMHC	-	Community Mental Health Center
CMHS	-	Center for Mental Health Services
CMS	-	Centers for Medicaid and Medicare Services
COD	-	Co-occurring Disorders (Mental Health and Substance Abuse)
CRG	-	Clinically Related Groups
CTT	-	Continuous Treatment Team
DCS	-	Department of Children's Services
DDRN	-	Dual Diagnosis Recovery Network
DFA	-	Department of Finance and Administration
DMC	-	Division of Managed Care
DMHDD	-	Department of Mental Health and Developmental Disabilities
DOC	-	Department of Correction
DOE	-	Department of Education
DOH	-	Department of Health
DRA	-	Dual Recovery Anonymous
DRSP	-	Division of Recovery Services and Planning
EBP	-	Evidence Based Practice
EPSDT	-	Early Periodic Screening, Diagnosis, and Treatment
FY	-	Fiscal Year
GAF	-	Global Assessment of Functioning
GED	-	General Education Development
HIV	-	Human Immunodeficiency Virus
HUD	-	Housing and Urban Development
I/P	-	Inpatient
IDEA	-	Individuals with Disabilities Education Act
IMD	-	Institute for Mental Diseases
JOH	-	Journey of Hope
MCO	-	Managed Care Organization
MHA	-	Mental Health Association
MHDDPC	-	DMHDD Planning and Policy Council
MHSN	-	Mental Health Safety Net
MOU	-	Memorandum of Understanding

ABBREVIATIONS GLOSSARY (Continued)

NAMI-TN	-	National Alliance for the Mentally Ill, Tennessee
NOMS	-	National Outcomes Measures System
PACT	-	Program for Assertive Community Treatment
PASRR	-	Pre-admission Screening and Resident Review
PATH	-	Projects for Assistance in the Transition from Homelessness
RIP	-	Regional Intervention Program
RMHI	-	Regional Mental Health Institute
RMHPC	-	Regional Mental Health Planning Council
SED	-	Serious Emotional Disturbance
SETH	-	Support, Employment, Transportation, and Housing
SMHPC	-	State Mental Health Planning and PolicyCouncil
SMI	-	Serious Mental Illness
SPMI	-	Serious and Persistent Mental Illness
TAMHO	-	Tennessee Association of Mental Health Organizations
TCPP	-	TennCare Partners Program
TMHCA	-	Tennessee Mental Health Consumers Association
TOMS	-	Tennessee Outcomes Measurement System
TPG	-	Target Population Group
TSPN	-	Tennessee Suicide Prevention Network
TVC	-	Tennessee Voices for Children